DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: St. Benedicts Senior Community		**Report Number:** H5350061	**Date of Visit:** July 6 and 7, 2017
Facility Address: 1810 Minnesota Boulevard SE		**Time of Visit:** 3:00 p.m. to 7:00 p.m. 10:30 a.m. to 3:30 p.m.	**Date Concluded:** December 29, 2017
Facility City: St Cloud		**Investigator's Name and Title:** Jessica Sellner, RN, Special Investigator	
State: Minnesota	**ZIP:** 56304	**County:** Sherburne	

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was abused when the resident was found to be restrained to his/ her wheelchair with a gait belt.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, abuse occurred when the alleged perpetrator (AP) physically restrained the resident in the wheelchair and/or recliner several times within a three week period to prevent the resident from standing up.

The resident had severe cognitive impairment, walked with two staff, and was assessed as not safe to walk without staff as s/he had fallen in the past when attempting to walk independently.

The night shift staff observed the resident sitting in the wheelchair with a gait belt around her/his waist. The belt was tucked beneath the wheelchair handles to prevent the resident from self transferring. The resident was attempting to stand from the wheelchair, but was not able to as a gait belt was restraining the resident in the wheelchair. The facility investigation indicated staff saw the resident sitting in the wheelchair near the nurses desk with a blanket over their lap. The resident attempted to stand up out of the wheelchair and the blanket fell off the resident. Staff noted the gait belt around the residents waist restraining the resident in the wheelchair. The house charge nurse was notified and directed the AP to remove the gait belt. The facility indicated during the investigation it was determined the AP had restrained the resident on three

different occasions in the prior three weeks. The AP used a gait belt, a bed sheet tied around the residents waist and secured on the back of the wheelchair, and also raised the foot rest on a recliner and put a foot stool under the foot rest so the resident was unable to get out of the recliner.

The resident was unable to be interviewed due to his/her cognitive status.

When interviewed, the AP stated s/he used a gait belt to remind the resident to stay sitting in the wheelchair so the resident didn't attempt to self transfer and fall. The AP stated s/he had used the gait belt other times in the past three weeks to restrain the resident in the wheelchair and it worked well to keep the resident in the wheelchair. The AP stated s/he was aware residents could not be restrained.

During staff interviews, three staff members were aware the AP had restrained the resident in the wheelchair and/or the recliner in the past three weeks. None of the three staff reported to the facility the AP restrained the resident although staff stated they were aware the facility policy indicated restraints could not be used.

The facility re-educated all staff regarding restraints and reporting abuse immediately. The AP was suspended during the course of the investigation, and terminated from employment at the completion of the facility investigation.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☒ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The AP, and all staff at the facility, had been educated on the facility policy regarding restraints and abuse upon hire and annually. The facility failed to ensure the AP, and other staff at the facility, followed the facility policy.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion,

including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Meal Intake Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Activities Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Other, specify:

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Call Light Audits
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Six

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: Cognitively impaired

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Three

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 16

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ◯ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ◯ No ◯ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
_____	_____	_____	_____	_____	_____

If unable to contact was subpoena issued: ◯ Yes, date subpoena was issued _____ ◯ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Use of Equipment
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Restorative Care
☒ Transfers
☒ Facility Tour
☒ Injury
☒ Other: Restraint use

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A

Was equipment being operated in safe manner: ◯ Yes ◯ No ◉ N/A

Were photographs taken: ◯ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

St Cloud Police Department

St Cloud City Attorney

Sherburne County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	R-C 12/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(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 A Post Certification revisit was conducted on December 22, 2017, to follow up on deficiencies issued relate to complaint H5350061. St Benedicts Senior Community is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

12/31/2017

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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	00774	A. BUILDING: _____ B. WING _____	R-C 12/22/2017

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ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5350061. St Benedicts Senior Community was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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	00774	A. BUILDING: _____ B. WING _____	R-C 12/22/2017

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{2 000}	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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	245350	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5350061. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) 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 symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is	F 221		

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

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 221	Continued From page 1 indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from physical restraints for 1 of 7 residents, R1, reviewed who had a physical restraint applied by staff with no corresponding assessment or physician order. Findings include: R1's significant change Minimum Data Set (MDS) dated 4/10/17, indicated the resident had severe cognitive impairment, had no physical restraints, and required extensive assistance of one staff with all activities of daily living. R1's care plan dated 5/15/17, indicated the resident was receiving hospice services for end of life care, had terminal agitation, and directed staff to provide resident one on one time, walk the resident when she became agitated, and turn on the television for R1. R1's progress notes dated 7/3/17, at 11:11 a.m. indicated R1 was observed the following evening by staff sitting in the wheelchair with a transfer belt around her waist and the belt was behind her tucked beneath the handles to prevent the resident from self transferring from the wheelchair. The resident was noted to be attempting to stand from the wheelchair and was not able to because the transfer belt was restraining R1 in the wheelchair. A progress note dated 7/3/17, at 1:55 p.m.	F 221		

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F 221	Continued From page 2	F 221		

indicated there was no bruising noted to R1 where the transfer belt was placed to restrain her in the wheelchair.

When interviewed on 7/7/17, at 10:45 a.m. nursing assistant (NA)-K stated she worked the overnight shift on 7/2/17, from 11:00 p.m. to 6:30 a.m. on 7/3/17. NA-K stated when arriving to work that evening at approximately 11:00 p.m., R1 was sitting in her wheelchair by the nurses station next to licensed practical nurse (LPN)-I. NA-K stated R1 was attempting to stand up out of her wheelchair but was unable to because she had a transfer belt around her waist and the belt was hooked on the back of the wheelchair and secure so R1 was unable to remove it. LPN-I stated she was using the transfer belt to keep R1 in her wheelchair because the resident kept attempting to stand up. NA-K stated approximately an hour later LPN-I stated registered nurse (RN)-Q, who was also the charge nurse that evening, had questioned LPN-I about the transfer belt around R1, so LPN-I removed the belt. NA-K stated R1 continued to try to stand up out of the wheelchair, and LPN-I assisted R1 into the recliner and elevated the footrest. NA-K stated R1 was able to push the footrest down and attempt to stand, so LPN-I placed a footstool under the recliner footrest so R1 was unable to get out of the recliner.

When interviewed on 7/7/17, at 11:10 a.m. LPN-I stated she worked the overnight shift on 7/2/17, and R1 was very unsteady and attempting to stand from the wheelchair. LPN-I stated she used a transfer belt wrapped around R1's waist and looped the belt around the back of the wheelchair to prevent R1 from standing. LPN-I did not consult with the physician regarding using a

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F 221	Continued From page 3	F 221		

restraint on R1, and there was no order directing a restraint to be used to keep R1 in the wheelchair. LPN-I stated when R1 was restrained in the wheelchair she had to leave her alone for a short time while assisting another resident with cares. When LPN-I walked away, NA-N came into the unit and observed R1 in the wheelchair with the transfer belt around her waist restraining R1 in the wheelchair and notified RN-Q. LPN-I stated RN-Q told her to remove the transfer belt from around the wheelchair because it was a restraint. LPN-I stated R1 was difficult to monitor because she was always moving and was not safe to walk. LPN-I stated she had restrained R1 in the wheelchair using the transfer belt several times in the past three weeks and it did prevent R1 from self transferring. LPN-I stated she had used a footstool under the reclining chair footrest for R1 when the resident was restless and attempting to stand. However, LPN-I stated this wasn't the best options as R1 had attempted to crawl off the side of the recliner if she was not able to lower the footrest.

When interviewed on 7/17/17, at 12:20 p.m. NA-N stated she worked the overnight shift on 7/2/17-7/3/17. NA-N stated she was conducting safety audits of the facility. When arriving on R1's unit on 7/3/17, at approximately 1:30 a.m. NA-N was unable to locate any staff. R1 was sitting in her wheelchair by the nurses desk with the brakes locked on the wheelchair and R1 had a blanket around her lap. NA-N stated R1 started to become restless and attempted to stand up and the blanket fell off her lap. NA-N stated she saw R1 was being restrained into the wheelchair by a transfer belt and was unable to stand. NA-N called RN-Q and requested he come to the unit immediately. NA-N stated about 8 minutes

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F 221	Continued From page 4 passed from the time she came onto the unit until she saw any staff from the unit. During interview on 7/20/17, at 11:10 a.m. RN-H stated she worked an overnight shift on 6/27/17-6/28/17, with LPN-I. R1 was restless, attempting to stand and walk, and was leaning forward in the wheelchair. RN-H stated LPN-I wrapped a bedsheet around R1's waist and tied it around the back of the wheelchair to prevent R1 from standing up. RN-H stated R1 was restrained in the wheelchair approximately 3-4 hours. The facility policy titled Restraints- Physical dated 3/2008, indicated prior to the use of any restraint the nurse would inform the resident and/or the responsible party of the resident's condition and circumstances related to restraint use, the potential risk and benefits related to use of restraints, and alternatives to restraint use. Any restraint required a physician order indicating the medical reason, duration of use, type of restraint, and observation and release protocol for the restraint. Emergency use of a restraint required specific documented interventions including emergency necessitating restraint use, the physician order, resident and/ or legal representative informed consent, duration of use, type of restraint, and observation and release protocol.	F 221		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who-	F 225		

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F 225	Continued From page 5 (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 225		

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	245350	A. BUILDING _____ B. WING _____	C 11/15/2017

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ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(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 225	Continued From page 6 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure allegations of staff mistreatment were reported for 1 of 7 residents, R1, reviewed who were physically restrained in their wheelchair without a physician order or medical justification. Findings include: R1's significant change Minimum Data Set (MDS) dated 4/10/17, indicated the resident had severe cognitive impairment, had no physical restraints, and required extensive assistance of one staff with all activities of daily living. R1's care plan dated 5/15/17, indicated the resident was receiving hospice services for end of life care, had terminal agitation, and directed staff to provide resident one on one time, walk the resident when she became agitated, and turn on	F 225		

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F 225	Continued From page 7 the television for R1. R1's progress notes dated 7/3/17, at 11:11 a.m. indicated R1 was observed by staff sitting in the wheelchair with a transfer belt around her waist and the belt was behind her tucked beneath the handles to prevent the resident from self transferring from the wheelchair during the night shift on 7/2/17-7/3/17. The resident was noted to be attempting to stand from the wheelchair and was not able to because the transfer belt was restraining R1 in the wheelchair. A progress note dated 7/3/17, at 1:55 p.m. indicated there was no bruising noted to R1 where the transfer belt was placed to restrain her in the wheelchair. The facility incident report dated 7/3/17, indicated the facility reported R1 was restrained in the wheelchair to the state agency on 7/3/17. When interviewed on 7/7/17, at 10:45 a.m. nursing assistant (NA)-K stated she worked the overnight shift on 7/2/17, from 11:00 p.m. to 6:30 a.m. on 7/3/17. NA-K stated when arriving to work that evening at approximately 11:00 p.m., R1 was sitting in her wheelchair by the nurses station next to licensed practical nurse (LPN)-I. NA-K stated R1 was attempting to stand up out of her wheelchair but was unable to because she had a transfer belt around her waist and the belt was hooked on the back of the wheelchair and secured so R1 was not able to remove the belt. LPN-I stated she was using the transfer belt on R1 because the resident kept attempting to stand up. NA-K stated approximately an hour later LPN-I stated registered nurse (RN)-Q, who was also the charge nurse that evening, had	F 225		

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F 225	Continued From page 8	F 225		

questioned LPN-I about the transfer belt around R1, so LPN-I removed the belt. NA-K stated R1 continued to try to stand up out of the wheelchair, and LPN-I assisted R1 into the recliner and elevated the footrest. NA-K stated R1 was able to push the footrest down and attempt to stand, so LPN-I placed a footstool under the recliner footrest so R1 was unable to get out of the recliner. NA-K stated she did not report this to anyone at the facility.

When interviewed on 7/7/17, at 11:10 a.m. LPN-I stated she worked the overnight shift on 7/2/17, and R1 was very unsteady and attempting to stand from the wheelchair. LPN-I stated she used a transfer belt wrapped around R1 and looped the belt around the back of the wheelchair and secured the belt to prevent R1 from standing. LPN-I stated she had restrained R1 in the wheelchair using the transfer belt several times in the past three weeks to prevent R1 from self transferring. LPN-I stated she also used a footstool under the reclining chair footrest for R1 when the resident was restless and attempting to stand. LPN-I stated she was aware restraints could not be used, however, she felt it was the best option to keep R1 safe to prevent her from falling.

When interviewed on 7/7/17, at 1:40 p.m. NA-J stated approximately two weeks ago she attempted to put the transfer belt around R1's waist and hook it onto the handles on the back of the wheelchair to keep R1 from standing up in the wheelchair. NA-J stated LPN-I asked her about restraining R1 with the transfer belt, but never told her she could not use the belt to keep R1 in the wheelchair. NA-J stated she only attempted once to keep R1 in the wheelchair with the

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F 225	Continued From page 9 transfer belt because she wasn't sure if it was okay to do that, and she, "Didn't want to get into trouble." NA-J stated she had also attempted to keep R1 in the recliner by putting up the reclining footrest and placing a footstool under the footrest so R1 could not put the footrest down and get out of the chair. However, R1 would attempt to climb out of the chair so staff had to watch her closely. When interviewed on 7/7/17, at 2:30 p.m. the administrator stated all staff are responsible to report allegations of staff mistreatment. The administrator stated if staff were aware R1 was being restrained, this should have been reported immediately to administration and to the state agency. During interview on 7/20/17, at 11:10 a.m. RN-H stated she worked an overnight shift on 6/27/17-6/28/17, with LPN-I. R1 was restless, attempting to stand and walk, and was leaning forward in the wheelchair. RN-H stated LPN-I wrapped a bedsheet around R1's waist and tied it around the back of the wheelchair to prevent R1 from standing up. RN-H stated R1 was restrained in the wheelchair approximately 3-4 hours. RN-H stated she felt uncomfortable with LPN-I restraining R1, but didn't report it to the facility until 7/3/17, after hearing from other staff about LPN-I restraining R1 in the wheelchair with the transfer belt the prior evening on 7/2/17-7/3/17. Although multiple staff members were aware R1 was restrained in the wheelchair, this was not reported to the administrator or the state agency. The undated facility policy titled Vulnerable Adults- Abuse Prevention Policy, indicated all	F 225		

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F 225	Continued From page 10 allegations of mistreatment, neglect, or abuse were to reported immediately to the administrator and the state agency. If a staff member was suspected of abuse, neglect, or maltreatment of a resident the administrator or director of nursing may relieve/suspend, or place on administrative leave the individual of their duties until the investigation is complete.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse,	F 226		

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F 226	Continued From page 11 neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their policy to report incidents of mistreatment to the administrator and the state agency according to the facility policy for 1 of 7 residents, R1, reviewed who were physically restrained in their wheelchair without a physician order or medical justification. Findings include: The undated facility policy titled Vulnerable Adults- Abuse Prevention Policy, indicated all allegations of mistreatment, neglect, or abuse were to reported immediately to the administrator and the state agency. If a staff member was suspected of abuse, neglect, or maltreatment of a resident the administrator or director of nursing may relieve/suspend, or place on administrative leave the individual of their duties until the investigation is complete. R1's progress notes dated 7/3/17, at 11:11 a.m. indicated R1 was observed by staff sitting in the wheelchair with a transfer belt around her waist and the belt was behind her tucked beneath the handles to prevent the resident from self transferring from the wheelchair during the night shift on 7/2/17-7/3/17. The resident was noted to be attempting to stand from the wheelchair and was not able to because the transfer belt was restraining R1 in the wheelchair.	F 226		

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F 226	Continued From page 12 The facility incident report dated 7/3/17, indicated the facility reported to the state agency R1 was restrained in the wheelchair on 7/3/17. When interviewed on 7/7/17, at 11:10 a.m. LPN-I stated she worked the overnight shift on 7/2/17, and R1 was very unsteady and attempting to stand from the wheelchair. LPN-I stated she used a transfer belt wrapped around R1's waist and looped the belt around the back of the wheelchair and secured it to prevent R1 from standing. LPN-I stated she had restrained R1 in the wheelchair using the transfer belt several times in the past three weeks to prevent R1 from self transferring. LPN-I stated she also used a footstool under the reclining chair footrest for R1 when the resident was restless and attempting to stand. LPN-I stated she was aware restraints could not be used, however, she felt it was the best option to keep R1 safe to prevent her from falling. When interviewed on 7/7/17, at 1:40 p.m. NA-J stated approximately two weeks ago she attempted to put the transfer belt around R1's waist and hook it onto the handles on the back of the wheelchair to keep R1 from standing up in the wheelchair. NA-J stated LPN-I asked her about restraining R1 with the transfer belt, but never told her she could not use the belt to keep R1 in the wheelchair. NA-J stated she had also attempted to keep R1 in the recliner by putting up the reclining footrest and placing a footstool under the footrest so R1 could not put the footrest down and get out of the chair. However, R1 would attempt to climb out of the chair so staff had to watch her closely. When interviewed on 7/7/17, at 2:30 p.m. the administrator stated all staff are responsible to	F 226		

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F 226	Continued From page 13 report allegations of staff mistreatment. The administrator stated if staff were aware R1 was being restrained, this should have been reported to administration and to the state agency according to the facility policy. During interview on 7/20/17, at 11:10 a.m. RN-H stated she worked an overnight shift on 6/27/17-6/28/17, with LPN-I. R1 was restless, attempting to stand and walk, and was leaning forward in the wheelchair. RN-H stated LPN-I wrapped a bedsheet around R1's waist and tied it around the back of the wheelchair to prevent R1 from standing up. RN-H stated R1 was restrained in the wheelchair approximately 3-4 hours. RN-H stated she felt uncomfortable with LPN-I restraining R1, but didn't report it to the facility according to the facility policy until 7/3/17, after hearing from other staff about LPN-I restraining R1 in the wheelchair with the transfer belt the prior evening on 7/2/17-7/3/17. Although several staff were aware R1 had been restrained multiple times in the previous three weeks, staff did not report this to the administrator or the state agency according to the facility policy.	F 226		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5350061. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

Minnesota Department of Health

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices	2 505		

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2 505	Continued From page 2 on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from physical restraints for 1 of 7 residents, R1, reviewed who had a physical restraint applied by staff with no corresponding assessment or physician order. Findings include: R1's significant change Minimum Data Set (MDS) dated 4/10/17, indicated the resident had severe cognitive impairment, had no physical restraints, and required extensive assistance of one staff with all activities of daily living. R1's care plan dated 5/15/17, indicated the resident was receiving hospice services for end of	2 505		

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2 505	Continued From page 3 life care, had terminal agitation, and directed staff to provide resident one on one time, walk the resident when she became agitated, and turn on the television for R1. R1's progress notes dated 7/3/17, at 11:11 a.m. indicated R1 was observed the following evening by staff sitting in the wheelchair with a transfer belt around her waist and the belt was behind her tucked beneath the handles to prevent the resident from self transferring from the wheelchair. The resident was noted to be attempting to stand from the wheelchair and was not able to because the transfer belt was restraining R1 in the wheelchair. A progress note dated 7/3/17, at 1:55 p.m. indicated there was no bruising noted to R1 where the transfer belt was placed to restrain her in the wheelchair. When interviewed on 7/7/17, at 10:45 a.m. nursing assistant (NA)-K stated she worked the overnight shift on 7/2/17, from 11:00 p.m. to 6:30 a.m. on 7/3/17. NA-K stated when arriving to work that evening at approximately 11:00 p.m., R1 was sitting in her wheelchair by the nurses station next to licensed practical nurse (LPN)-I. NA-K stated R1 was attempting to stand up out of her wheelchair but was unable to because she had a transfer belt around her waist and the belt was hooked on the back of the wheelchair and secure so R1 was unable to remove it. LPN-I stated she was using the transfer belt to keep R1 in her wheelchair because the resident kept attempting to stand up. NA-K stated approximately an hour later LPN-I stated registered nurse (RN)-Q, who was also the charge nurse that evening, had questioned LPN-I about the transfer belt around R1, so LPN-I	2 505		

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2 505	Continued From page 4 removed the belt. NA-K stated R1 continued to try to stand up out of the wheelchair, and LPN-I assisted R1 into the recliner and elevated the footrest. NA-K stated R1 was able to push the footrest down and attempt to stand, so LPN-I placed a footstool under the recliner footrest so R1 was unable to get out of the recliner. When interviewed on 7/7/17, at 11:10 a.m. LPN-I stated she worked the overnight shift on 7/2/17, and R1 was very unsteady and attempting to stand from the wheelchair. LPN-I stated she used a transfer belt wrapped around R1's waist and looped the belt around the back of the wheelchair to prevent R1 from standing. LPN-I did not consult with the physician regarding using a restraint on R1, and there was no order directing a restraint to be used to keep R1 in the wheelchair. LPN-I stated when R1 was restrained in the wheelchair she had to leave her alone for a short time while assisting another resident with cares. When LPN-I walked away, NA-N came into the unit and observed R1 in the wheelchair with the transfer belt around her waist restraining R1 in the wheelchair and notified RN-Q. LPN-I stated RN-Q told her to remove the transfer belt from around the wheelchair because it was a restraint. LPN-I stated R1 was difficult to monitor because she was always moving and was not safe to walk. LPN-I stated she had restrained R1 in the wheelchair using the transfer belt several times in the past three weeks and it did prevent R1 from self transferring. LPN-I stated she had used a footstool under the reclining chair footrest for R1 when the resident was restless and attempting to stand. However, LPN-I stated this wasn't the best options as R1 had attempted to crawl off the side of the recliner if she was not able to lower the footrest.	2 505		

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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) COMPLETE DATE
2 505	Continued From page 5 When interviewed on 7/17/17, at 12:20 p.m. NA-N stated she worked the overnight shift on 7/2/17-7/3/17. NA-N stated she was conducting safety audits of the facility. When arriving on R1's unit on 7/3/17, at approximately 1:30 a.m. NA-N was unable to locate any staff. R1 was sitting in her wheelchair by the nurses desk with the brakes locked on the wheelchair and R1 had a blanket around her lap. NA-N stated R1 started to become restless and attempted to stand up and the blanket fell off her lap. NA-N stated she saw R1 was being restrained into the wheelchair by a transfer belt and was unable to stand. NA-N called RN-Q and requested he come to the unit immediately. NA-N stated about 8 minutes passed from the time she came onto the unit until she saw any staff from the unit. During interview on 7/20/17, at 11:10 a.m. RN-H stated she worked an overnight shift on 6/27/17-6/28/17, with LPN-I. R1 was restless, attempting to stand and walk, and was leaning forward in the wheelchair. RN-H stated LPN-I wrapped a bedsheet around R1's waist and tied it around the back of the wheelchair to prevent R1 from standing up. RN-H stated R1 was restrained in the wheelchair approximately 3-4 hours. The facility policy titled Restraints- Physical dated 3/2008, indicated prior to the use of any restraint the nurse would inform the resident and/or the responsible party of the resident's condition and circumstances related to restraint use, the potential risk and benefits related to use of restraints, and alternatives to restraint use. Any restraint required a physician order indicating the medical reason, duration of use, type of restraint, and observation and release protocol for the restraint. Emergency use of a restraint required	2 505		

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	00774	A. BUILDING: _____ B. WING _____	C 11/15/2017

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2 505	Continued From page 6 specific documented interventions including emergency necessitating restraint use, the physician order, resident and/ or legal representative informed consent, duration of use, type of restraint, and observation and release protocol. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding physical restraint use. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 505		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced	21850		

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21850	Continued From page 7 by: Based on interview and record review the facility failed to ensure 1 of 7 residents, R1, were free from abuse when the resident was physically restrained in the wheelchair multiple times by a staff member without medical justification and a physician order. Findings include: R1's significant change Minimum Data Set (MDS) dated 4/10/17, indicated the resident had severe cognitive impairment, had no physical restraints, and required extensive assistance of one staff with all activities of daily living. R1's care plan dated 5/15/17, indicated the resident was receiving hospice services for end of life care, had terminal agitation, and directed staff to provide resident one on one time, walk the resident when she became agitated, and turn on the television for R1. R1's progress notes dated 7/3/17, at 11:11 a.m. indicated R1 was observed the following evening by staff sitting in the wheelchair with a transfer belt around her waist and the belt was behind her tucked beneath the handles to prevent the resident from self transferring from the wheelchair. The resident was noted to be attempting to stand from the wheelchair and was not able to because the transfer belt was restraining R1 in the wheelchair. A progress note dated 7/3/17, at 1:55 p.m. indicated there was no bruising noted to R1 where the transfer belt was placed to restrain her in the wheelchair. When interviewed on 7/7/17, at 10:45 a.m.	21850		

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21850	Continued From page 8 nursing assistant (NA)-K stated she worked the overnight shift on 7/2/17, from 11:00 p.m. to 6:30 a.m. on 7/3/17. NA-K stated when arriving to work that evening at approximately 11:00 p.m., R1 was sitting in her wheelchair by the nurses station next to licensed practical nurse (LPN)-I. NA-K stated R1 was attempting to stand up out of her wheelchair but was unable to because she had a transfer belt around her waist and the belt was hooked on the back of the wheelchair and secure so R1 was unable to remove it. LPN-I stated she was using the transfer belt to keep R1 in her wheelchair because the resident kept attempting to stand up. NA-K stated approximately an hour later LPN-I stated registered nurse (RN)-Q, who was also the charge nurse that evening, had questioned LPN-I about the transfer belt around R1, so LPN-I removed the belt. NA-K stated R1 continued to try to stand up out of the wheelchair, and LPN-I assisted R1 into the recliner and elevated the footrest. NA-K stated R1 was able to push the footrest down and attempt to stand, so LPN-I placed a footstool under the recliner footrest so R1 was unable to get out of the recliner. When interviewed on 7/7/17, at 11:10 a.m. LPN-I stated she worked the overnight shift on 7/2/17, and R1 was very unsteady and attempting to stand from the wheelchair. LPN-I stated she used a transfer belt wrapped around R1's waist and looped the belt around the back of the wheelchair to prevent R1 from standing. LPN-I did not consult with the physician regarding using a restraint on R1, and there was no order directing a restraint to be used to keep R1 in the wheelchair. LPN-I stated when R1 was restrained in the wheelchair she had to leave her alone for a short time while assisting another resident with cares. When LPN-I walked away,	21850		

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21850	Continued From page 9 NA-N came into the unit and observed R1 in the wheelchair with the transfer belt around her waist restraining R1 in the wheelchair and notified RN-Q. LPN-I stated RN-Q told her to remove the transfer belt from around the wheelchair because it was a restraint. LPN-I stated R1 was difficult to monitor because she was always moving and was not safe to walk. LPN-I stated she had restrained R1 in the wheelchair using the transfer belt several times in the past three weeks and it did prevent R1 from self transferring. LPN-I stated she had used a footstool under the reclining chair footrest for R1 when the resident was restless and attempting to stand. However, LPN-I stated this wasn't the best options as R1 had attempted to crawl off the side of the recliner if she was not able to lower the footrest. When interviewed on 7/17/17, at 12:20 p.m. NA-N stated she worked the overnight shift on 7/2/17-7/3/17. NA-N stated she was conducting safety audits of the facility. When arriving on R1's unit on 7/3/17, at approximately 1:30 a.m. NA-N was unable to locate any staff. R1 was sitting in her wheelchair by the nurses desk with the brakes locked on the wheelchair and R1 had a blanket around her lap. NA-N stated R1 started to become restless and attempted to stand up and the blanket fell off her lap. NA-N stated she saw R1 was being restrained into the wheelchair by a transfer belt and was unable to stand. NA-N called RN-Q and requested he come to the unit immediately. NA-N stated about 8 minutes passed from the time she came onto the unit until she saw any staff from the unit. During interview on 7/20/17, at 11:10 a.m. RN-H stated she worked an overnight shift on 6/27/17-6/28/17, with LPN-I. R1 was restless, attempting to stand and walk, and was leaning	21850		

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21850	Continued From page 10 forward in the wheelchair. RN-H stated LPN-I wrapped a bedsheet around R1's waist and tied it around the back of the wheelchair to prevent R1 from standing up. RN-H stated R1 was restrained in the wheelchair approximately 3-4 hours. The facility policy titled Restraints- Physical dated 3/2008, indicated prior to the use of any restraint the nurse would inform the resident and/or the responsible party of the resident's condition and circumstances related to restraint use, the potential risk and benefits related to use of restraints, and alternatives to restraint use. Any restraint required a physician order indicating the medical reason, duration of use, type of restraint, and observation and release protocol for the restraint. Emergency use of a restraint required specific documented interventions including emergency necessitating restraint use, the physician order, resident and/ or legal representative informed consent, duration of use, type of restraint, and observation and release protocol. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure each resident's bill of rights are upheld and residents are free from maltreatment. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21850		

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21980	Continued From page 11	21980		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead	21980		

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21980	Continued From page 12 agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure allegations of staff mistreatment were reported for 1 of 7 residents, R1, reviewed who were physically restrained in their wheelchair without a physician order or medical justification. Findings include: R1's significant change Minimum Data Set (MDS) dated 4/10/17, indicated the resident had severe cognitive impairment, had no physical restraints, and required extensive assistance of one staff with all activities of daily living. R1's care plan dated 5/15/17, indicated the resident was receiving hospice services for end of life care, had terminal agitation, and directed staff to provide resident one on one time, walk the resident when she became agitated, and turn on the television for R1. R1's progress notes dated 7/3/17, at 11:11 a.m. indicated R1 was observed by staff sitting in the wheelchair with a transfer belt around her waist and the belt was behind her tucked beneath the	21980		

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21980	Continued From page 13 handles to prevent the resident from self transferring from the wheelchair during the night shift on 7/2/17-7/3/17. The resident was noted to be attempting to stand from the wheelchair and was not able to because the transfer belt was restraining R1 in the wheelchair. A progress note dated 7/3/17, at 1:55 p.m. indicated there was no bruising noted to R1 where the transfer belt was placed to restrain her in the wheelchair. The facility incident report dated 7/3/17, indicated the facility reported R1 was restrained in the wheelchair to the state agency on 7/3/17. When interviewed on 7/7/17, at 10:45 a.m. nursing assistant (NA)-K stated she worked the overnight shift on 7/2/17, from 11:00 p.m. to 6:30 a.m. on 7/3/17. NA-K stated when arriving to work that evening at approximately 11:00 p.m., R1 was sitting in her wheelchair by the nurses station next to licensed practical nurse (LPN)-I. NA-K stated R1 was attempting to stand up out of her wheelchair but was unable to because she had a transfer belt around her waist and the belt was hooked on the back of the wheelchair and secured so R1 was not able to remove the belt. LPN-I stated she was using the transfer belt on R1 because the resident kept attempting to stand up. NA-K stated approximately an hour later LPN-I stated registered nurse (RN)-Q, who was also the charge nurse that evening, had questioned LPN-I about the transfer belt around R1, so LPN-I removed the belt. NA-K stated R1 continued to try to stand up out of the wheelchair, and LPN-I assisted R1 into the recliner and elevated the footrest. NA-K stated R1 was able to push the footrest down and attempt to stand, so LPN-I placed a footstool under the recliner	21980		

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21980	Continued From page 14 footrest so R1 was unable to get out of the recliner. NA-K stated she did not report this to anyone at the facility. When interviewed on 7/7/17, at 11:10 a.m. LPN-I stated she worked the overnight shift on 7/2/17, and R1 was very unsteady and attempting to stand from the wheelchair. LPN-I stated she used a transfer belt wrapped around R1 and looped the belt around the back of the wheelchair and secured the belt to prevent R1 from standing. LPN-I stated she had restrained R1 in the wheelchair using the transfer belt several times in the past three weeks to prevent R1 from self transferring. LPN-I stated she also used a footstool under the reclining chair footrest for R1 when the resident was restless and attempting to stand. LPN-I stated she was aware restraints could not be used, however, she felt it was the best option to keep R1 safe to prevent her from falling. When interviewed on 7/7/17, at 1:40 p.m. NA-J stated approximately two weeks ago she attempted to put the transfer belt around R1's waist and hook it onto the handles on the back of the wheelchair to keep R1 from standing up in the wheelchair. NA-J stated LPN-I asked her about restraining R1 with the transfer belt, but never told her she could not use the belt to keep R1 in the wheelchair. NA-J stated she only attempted once to keep R1 in the wheelchair with the transfer belt because she wasn't sure if it was okay to do that, and she, "Didn't want to get into trouble." NA-J stated she had also attempted to keep R1 in the recliner by putting up the reclining footrest and placing a footstool under the footrest so R1 could not put the footrest down and get out of the chair. However, R1 would attempt to climb out of the chair so staff had to watch her closely.	21980		

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21980	Continued From page 15 When interviewed on 7/7/17, at 2:30 p.m. the administrator stated all staff are responsible to report allegations of staff mistreatment. The administrator stated if staff were aware R1 was being restrained, this should have been reported immediately to administration and to the state agency. During interview on 7/20/17, at 11:10 a.m. RN-H stated she worked an overnight shift on 6/27/17-6/28/17, with LPN-I. R1 was restless, attempting to stand and walk, and was leaning forward in the wheelchair. RN-H stated LPN-I wrapped a bedsheet around R1's waist and tied it around the back of the wheelchair to prevent R1 from standing up. RN-H stated R1 was restrained in the wheelchair approximately 3-4 hours. RN-H stated she felt uncomfortable with LPN-I restraining R1, but didn't report it to the facility until 7/3/17, after hearing from other staff about LPN-I restraining R1 in the wheelchair with the transfer belt the prior evening on 7/2/17-7/3/17. Although multiple staff members were aware R1 was restrained in the wheelchair, this was not reported to the administrator or the state agency. The undated facility policy titled Vulnerable Adults- Abuse Prevention Policy, indicated all allegations of mistreatment, neglect, or abuse were to reported immediately to the administrator and the state agency. If a staff member was suspected of abuse, neglect, or maltreatment of a resident the administrator or director of nursing may relieve/suspend, or place on administrative leave the individual of their duties until the investigation is complete.	21980		

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21980	Continued From page 16 SUGGESTED METHOD OF CORRECTION: The administrator or designee could provide education to facility staff on reporting allegations of maltreatment to the state agency. The administrator or designee could ensure residents safety and well being by providing supervision and education to facility staff on abuse and neglect. The administrator or designee could provide monitoring for compliance in reporting allegations of maltreatment and could provide monitoring for resident safety. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21980		