Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 6, 2020

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

RE: CCN: 245378
Cycle Start Date: August 21, 2020

Dear Administrator:

On October 13, 2020, we notified you a remedy was imposed. On November 3, 2020 the Minnesota Department of Health 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 October 27, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 28, 2020 did not go into effect. (42 CFR 488.417 (b))

As we notified you in our letter of September 1, 2020, 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 September 22, 2020. 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
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

November 6, 2020

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

Re: Reinspection Results
Event ID: GT4K12

Dear Administrator:

On November 3, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 22, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 13, 2020

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

RE: CCN: 245378
Cycle Start Date: September 22, 2020

Dear Administrator:

On September 1, 2020, we informed you that we may impose enforcement remedies.

On September 22, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On September 16, 2020, the situation of immediate jeopardy to potential health and safety cited at scope and severity of K for tag F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

On September 17, 2020, the situation of immediate jeopardy to potential health and safety cited at scope and severity of J for tag F686 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal

regulations at 42 CFR § 488.417(a), effective October 28, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 28, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 28, 2020.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC) (Delete if not SQC and this note)

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

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Valley View Manor Hcc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 22, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 21, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132

Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program

Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
October 13, 2020

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

Re: State Nursing Home Licensing Orders
Event ID: GT4K11

Dear Administrator:

The above facility was surveyed on September 14, 2020 through September 22, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

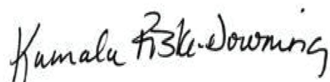
Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Licensing and Certification Program

Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

PENDING ACKNOWLEDGEMENT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	C 09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 9/14/20 through 9/22/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.

The following complaints were found to be SUBSTANTIATED: H5378022C and H5378023C with deficiencies cited at F600, F609, F610 and F686.

The survey resulted in an Immediate Jeopardy (IJ) at F600, when the facility failed to ensure 1 of 1 resident (R1) was free from abuse after allegations of sexual abuse were identified. The facility also failed to protect R1 from potential further abuse by advising the alleged perpetrator, licensed practical nurse (LPN)-A of her identity. This caused actual psychosocial harm to R1 as LPN-A was not immediately restricted from work pending an investigation and continued to provide care to 22 of other 44 residents in the facility for 2 additional days. The IJ began on 9/4/20, and the immediacy was removed on 9/16/20 at 4:45 p.m..

The survey resulted in another Immediate Jeopardy (IJ) at F686, when the facility failed to appropriately assess, monitor, and notify the physician for 1 of 1 resident (R2) with new onset pressure ulcer leading to hospitalization, wound debridement, and admission to hospice services. The IJ began on 8/23/20, when staff identified a new onset pressure ulcer. This caused actual harm to R1.The immediacy was removed on 9/17/20 at 3:45 p.m..

The above findings constituted substandard

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

Electronically Signed | | 10/21/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	C 09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

PENDING ACKNOWLEDGEMENT

(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	Continued From page 1 quality of care, and an extended survey was conducted from 9/16/20 through 9/21/20. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		10/27/20

PENDING ACKNOWLEDGEMENT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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F 600	Continued From page 2 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R1) was free from abuse after allegations of sexual abuse were identified. The facility also failed to protect R1 from potential further abuse by advising the alleged perpetrator, licensed practical nurse (LPN)-A of the resident's identity. This caused actual psychosocial harm to R1 as LPN-A was not immediately restricted from work pending an investigation and continued to provide care to 22 of 44 residents in the facility for 2 additional days. The IJ began on 9/4/20, when the facility failed to act on allegations of abuse, report to the State Agency and implement policies and procedures to keep R1 and other residents safe from further abuse. The facility administrator was notified of the IJ on 9/15/20 at 1:00 p.m.. The IJ was removed on 9/16/20 at 4:45 p.m., but non-compliance remained at the lower scope and severity G, actual harm that is not immediate jeopardy. Findings include: Review of the 9/8/20 report filed to the State Agency identified the social worker (SW) filed a report identifying the director of nursing (DON) was notified on 9/4/20 of inappropriate touching by licensed practical nurse (LPN)-A to R1. R1 advised staff she had not wanted LPN-A in her room. R1 alleged LPN-A, at an unknown date, had come into R1's room during the overnight hours and picked up R1's nasal cannula off the floor. LPN-A advised R1 there was fluid directly under the nasal cannula. R1 advised LPN-A it was from the condensation from humidified oxygen (O2). LPN-A picked up R1's bedding as	F 600	R1 had a risk management incident created 9-8-20. The MD was notified on 9-9-20. the Police were called on 9-15-20. Her vulnerable adult care plan was reviewed and updated and her preferences were reviewed and included and updated. Social Services met with R1 on 9-8-20, 9-9-20 and 9-10-20. MD was contacted to review resident request for external foley catheter. R1 was discharged on 9-22-20. On 9-15-20, All residents were interviewed and verbalized they feel safe living at the facility. All residents vulnerable adult care plan and preferences were reviewed and updated as needed. For new admissions the Social Service director will ask the residents preference regarding male or female caregivers and will review their care plan quarterly and as needed. RN-A was in-serviced on abuse investigation and reporting incidents with accuracy. LPN-A was terminated on 9-15-20. The Administrator and DON were in-serviced on abuse reporting, how to make a report in the SA portal, keeping resident complaints anonymous and suspension of employee/s upon suspicion of an allegation. The Administrator, Director of Nursing, ADON and Social Service Director all have access to the reporting platform and will be responsible for reporting allegations of abuse 24/7. Investigations with allegations of abuse will begin immediately. An on-call schedule was implemented on 9-28-20 on who to report to with any allegation of	

PENDING ACKNOWLEDGEMENT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	C 09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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F 600 Continued From page 3

R1 was laying in bed, and "moved his hands along her bottom". LPN-A had not advised R1 he was going to check her for alleged incontinence. Action taken by facility was identified as the DON advised LPN-A not to go into R1's room unless there was another staff person present. LPN-A was suspended per report on 9/7/20 pending an investigation.

Review of the facility's investigation notes, which began on 9/8/20 per the social worker, identified R1 advised (RN-A) on 9/4/20 at 10:10 p.m. she does not want a male care giver. LPN-A (no date or time) stated he came to work on 9/4/20 at 8:00 p.m. Over a week ago (unsure of date and time), the nurse aide on duty that night of the incident, was on break. R1 had reportedly put her call light on. LPN-A stated he answered it. LPN-A asked R1 what she needed. R1 stated she wanted cold water. LPN-A went to retrieve the water and upon return, noted a puddle or urine on the floor. LPN-A gave R1 her water and was trying to figure out where it came from. He lifted R1's cover slightly to check her bed. LPN-A advised R1 he was trying to figure out where the urine came from. LPN-A patted the bed. R1 had a "funny look on her face". LPN-A immediately put the covers down and cleaned up the floor. The notes identified R1 frequently refused to be changed and voids in her bed. "there was no inappropriate contact". We (facility staff) will care plan "no male caregivers. If he (LPN-A) needs to give medication or attend to medical tx [treatment], male nurses will take another female staff with them into the room". LPN-A was notified of his suspension on 9/8/20.

Further investigation notes identified LPN-A also remarked when he finished cleaning up R1's

F 600

abuse and posted at each nurses station by the phone. This schedule will be updated weekly.

Full time facility staff were in-serviced on 9-15-20 and 9-16-20 on the facility policy for reporting abuse with the emphasis of reporting incidents immediately. An All staff meeting will be held on 10-26-20 to review the facility abuse policy with emphasis on when Law Enforcement, MD, Primary Provider, Ombudsman and guardian will be notified.

Resident Care Audits along with abuse reporting, timeliness, resident preference and risk management incidents will begin 2x week for 2 weeks, weekly x3 weeks then monthly x 1 year. Audits will be taken to QAPI by the Administrator monthly x3 months for oversight and to ensure compliance.

Social Services and/or designee will be responsible for compliance.

PENDING ACKNOWLEDGEMENT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	C 09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

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F 600	Continued From page 4 floor, he and LPN-A were both "joking" when he left the room. On 9/8/20 at 8:35 a.m., R1 was interviewed by the SW. Notes of that interview identified R1 was outside smoking the evening of 9/4/20 and saw LPN-A report to work. R1 advised NA-A and NA-B not to let him come into her room since she felt uncomfortable. R1 was unclear on when the incident of inappropriate contact had occurred, but it was before 9/4/20. LPN-A had entered her room during the night, picked up her nasal cannula and said it was wet. R1 advised LPN-A it was wet from condensation. LPN-A left to get new tubing. R1 stated she was lying on her side with her back facing the doorway. When LPN-A returned, he touched her bottom inside her brief. R1 declared she had not used her call light to summon LPN-A that night. R1 declared no other staff has ever checked her for incontinence in that manner. R1 reported to the SW she felt safe. All staff were good to her except LPN-A. Both NA-A and NA-B were interviewed on 9/8/20. NA-B stated on the night of 9/4/20, R1 was outside smoking, came inside and was visibly shaking. NA-B asked if she was ok to which R1 replied "Not really. Seeing [LPN-A] makes me nervous". Both NA's took R1 to her room. R1 reported she had woken up to LPN-A checking her brief by sticking his finger in the back of her brief without telling her. R1 denied she had been wet. After talking to RN-A, NA-A and NA-B were advised LPN-A was not allowed in R1's room. Other staff were interviewed, but had no knowledge of the incident. Other residents were interviewed for safety and had no issues or concerns with staff. The Ombudsman was notified on 9/8/20 and the medical director was identified as being notified on 9/9/20. It was indicated in the report, after review of interviews, the facility identified "it was our belief LPN-A was	F 600		

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not abusive, nor had intent of abuse. We believed he failed at communication..". Corrective action identified were male staff were to be accompanied by a female staff per resident request. Before returning to work, LPN-A would be inserviced on the importance of explaining to residents what he is doing before hand. LPN-A was to have one-on-one supervision for 1 week. RN-A was to be inserviced on 9/14/20 on the importance of getting all the facts first hand and reporting timely. The facility was to monitor its corrective actions. There was no mention facility management had identified they failed to report the suspicion of a crime to the SA and law enforcement within 2 hours of the allegation. There was also no mention the facility had identified it failed to follow policies and procedures by immediately beginning and investigation and suspending alleged perpetrators upon notification of an allegation. There was also no mention of appropriate notification to family and or the residents representative, or primary care physician.

R1's 8/17/20, admission Minimum Data Set (MDS) assessment identified she was fully cognitive and required extensive assist of 1 staff for toileting.

R1's 8/18/20, progress notes identified R1 was admitted to the facility to receive rehabilitative services related to back pain and weakness and had pans to return home. Her admitting diagnoses were low back pain, muscle weakness, chronic obstructive pulmonary disease (COPD).

Interview on 9/14/20, with LPN-A identified the above incident occurred about a week ago to his

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F 600	Continued From page 6 knowledge. LPN-A was charge nurse on the night of the incident. R1 had put her call light on at approximately 3:00 a.m.. R1 had lost her oxygen tubing and it was laying on the floor in a puddle at the end of her bed by R1's feet. LPN-A left the room to get R1 new O2 tubing. LPN-A then proceeded to hook up R1's new tubing. R1 was laying in bed on her side, facing the wall, away from her door. R1 had a fluffy blanket. LPN-A advised her he was cleaning up the liquid found underneath her O2 tubing. R1's blanket kept falling into the liquid on the floor as he was trying to clean it up. R1 was "uncomfortable with me at that point". LPN-A proceeded to touch R1's incontinence pad. LPN-A acknowledged he had not advised R1 what he was going to check her brief. LPN-A asked R1 if she wanted another staff to help her clean up, but she refused. LPN-A then stated he made a "joke" to which R1 laughed and he left the room. R1 had never made concerns known about not receiving assistance from male staff members. LPN-A was unsure how R1 could have leaked urine by the foot of her bed, when the area directly below her bottom, in the middle of the bed, was dry. R1 had been known to refuse cares. In hindsight, he should have been "more clear" during cares. On 9/4/20, registered nurse (RN)-A had advised him he was not to go into R1's room at any time. RN-A advised LPN-A he had touched R1 inappropriately. RN-A was going to call the DON and alert her to R1's allegations. The DON called back and spoke with LPN-A. He was told to keep his distance from R1 and have another staff member give R1 her medications. He was suspended on 9/8/20 pending an investigation. He had worked 9/4/20, 9/5/20, and 9/6/20. LPN-A had come to the facility on 9/14/20 as he was turning in his resignation effective 9/19/20. He was to work his upcoming 3	F 600		

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scheduled shifts on 9/17/20 through 9/19/20. LPN-A was resigning over the allegations.

Review of LPN-A's August and September, 2020, staff schedules and time clock entries identified LPN-A was scheduled to work overnight shifts on 8/27/20, 8/31/20, 9/3/20, 9/4/20, 9/5/20, and 9/6/20.. LPN-A's timecard identified he worked on:
1) 8/27/20, beginning at 6:00 p.m. until 6:46 a.m.
2) 8/31/20, beginning at 9:58 p.m. until 6:51 a.m.
3) 9/3/20, beginning at 10:01 p.m. until 6:40 a.m.
4) 9/4/20, beginning at 8:03 p.m. until 6:46 a.m.
5) 9/5/20, beginning at 6:02 p.m. through 6:28 a.m.,
6) 9/6/20 beginning at 5:58 p.m. and finishing at 7:09 a.m.

Review of LPN-A's employee file identified a performance review dated 9/14/20. 3 resident complaints were identified on 5/5/20, 6/22/20, and 9/4/20. There was no indication LPN-A received any disciplinary actions or additional training or education following those resident complaints. The review identified LPN-A was flexible, worked both units and preferred working his night shift. LPN-A was identified having conflicts with some residents. LPN-A was to watch his tone as he had made "hurtful" statements without realizing it. It was identified he needed to "explain what you are doing, before you do it." LPN-A had a background check performed 6/3/20, which identified LPN-A had no criminal history reported. LPN-A was hired 11/18/19. There was no previous background check identified in his file. LPN-A had concern and problem resolution coaching's in his file. With regard to R3's complaint of LPN-A looking at her vagina, it was identified by the facility LPN-A had told R3 "You old people, its all in your head and

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you imagine things." R3 reported to management he made her "skin crawl" and was rude when other staff weren't around. He told her in a "creepy voice... I'm back.." when he returned to work. No disciplinary actions were included in LPN-A's file.

Interview on 9/14/20 with nursing assistant (NA)-A identified she was made aware of the incident on 9/4/20 by R1. R1 had reported to NA-A and NA-B she had seen LPN-A report for his shift that day at approximately 8:00 p.m.. R1 was outside. Staff noted R1 was afraid to come in and was shaking. R1 stated "I don't want that [expletive] working with me. R1 elaborated LPN-A had made her feel uncomfortable the last time he worked. LPN-A came into her room during the incident (unknown date) and started "poking" at her bottom. R1 wears an incontinence brief. R1 stated LPN-A was touching her inappropriately and did not know what to say to LPN-A at that time. R1 advised she was shocked and scared. R1 had not told anyone about the incident before 9/4/20, and she was afraid. R1 began to cry and would not go into any further detail with NA-A or NA-B. Both NA-A and NA-B left R1's room and advised RN-A immediately. RN-A went into R1's room and spoke to her about the incident. RN-A exited the room and looked to be visibly upset by the allegations R1 had advised her of. RN-A was witnessed telling LPN-A he was not to go into R1's room. R1 had never had any concerns with male staff. There was another male staff on the floor and R1 had no concerns with that male staff member.

Interview on 9/14/20 at 4:41 p.m. with NA-B identified R1 was a smoker and was outside the evening of 9/4/20. LPN-A had come in early,

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F 600	Continued From page 9 around 8:00 p.m. that day for his shift. NA-A and NA-B had noticed R1 was outside and rang the doorbell to come back into the facility. R1 was shaking and visibly upset. "She was petrified". NA-A and NA-B proceeded to ask R1 what the matter was. She was reluctant to say. R1 proceeded to tell the staff LPN-A had come into her room the other night when he worked. R1 advised LPN-A was checking her to see if she was wet. He stuck his fingers in her brief and touched her inappropriately. R1 takes care of herself and requires no assistance to toilet or put herself to bed etc. She only needed help when she was first admitted. R1 was expected to discharge soon. NA-A and NA-B left to find RN-A and advise her of the need to speak with R1 as soon as possible. RN-A was giving meds, and as soon as she was done, she would speak with R1. RN-A finished her medication pass and went to speak with R1 in her room. When RN-A came out of R1's room, she went to LPN-A who was working on that wing and advised him he was not to go into R1's room. Today on 9/14/20, when LPN-A came to work, R1 saw him come in. She began shaking. R1 kept watching the door to see if LPN-A was coming onto shift. Observation and interview on 9/14/20 at 5:00 p.m., with R1 identified LPN-A works overnight shifts. R1 goes to bed early. On the date of the incident which R1 recalled as the last time he worked but was unsure of that date. R1 stated LPN-A usually works weekends. It would have been the previous weekend night shifts to 9/4/20. R1 is awake and routinely sees the night shift report to work. R1 pointed to her calendar and identified the incident likely occurred between the dates of 8/28/20 and 8/31/20 which was the last scheduled weekend she saw him. LPN-A came	F 600		

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F 600	Continued From page 10 into R1's room. She was sound asleep but woke up startled when she realized LPN-A was in her room. R1 wore O2 at night. Occasionally this falls off. Her tubing was laying on the floor at the foot of her bed. LPN-A picked up the tubing, gave it to R1 and she advised him it was wet. LPN-A stated it was wet on the floor where her tubing had been. LPN-A then grabbed the wet tubing, left the room, and came back with new O2 tubing. LPN-A advised her the spot of liquid on the floor at her feet "looked like pee." R1 advised him that was condensation from her O2 tubing with humidified oxygen. R1 stated she had not felt wet in her brief. LPN-A showed her the rag after he wiped up the liquid on the floor and showed her it was dirty. R1 slept with the over-bed lights on at all times and would lay on her left side with her back away from the door, facing the wall. All of a sudden, R1 felt her covers being lifted and LPN-A was poking his fingers on her [expletive]. R1 stated she was" terrified." LPN-A had not said anything. He would start feeling her bottom, then stop. She heard clicking noises but was unsure what they were coming from. She thought it sounded like a pen light nurses use, but never saw any flash or light of any kind. R1 denied LPN-A had penetrated her in any way. His finger was on my butt check going up and down. R1 stated she had never been touched like that before. LPN-A was not touching her brief. R1 toilets herself and had no reason for LPN-A to attempt to check her brief for wetness. R1 identified she was "so scared" and "hadn't had the nerve to talk." LPN-A finally said, "Do you need to be changed?" R1 was able to say "No". LPN-A replied to her "Alright then" and left her room. R1 stated LPN-A was very intentionally touching her buttocks and was not in any way on her brief. No staff had ever touched her that way	F 600		

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before. R1 has never had any concerns with any male staff at any health facility. R1 elaborated the wet spot on the floor was by her feet, not on the floor directly below her bottom. R1 was scared that night and again today on 9/14/20, when she saw LPN-A arrive for work. R1 was afraid LPN-A was coming back to work. R1 stated when she saw LPN-A today arrive for work, she started shaking, and got a "creepy" feeling in her stomach with nausea. R1 does not feel safe around LPN-A. "I can talk! Others [residents] can't". R1 was going home soon and walked independently with cares. Observations during interview of R1 identified was visibly shaken was teary eyed and expressed anger throughout the interview.

Interview on 9/14/20 at 6:06 p.m. with RN-A identified she was made aware of the allegation of sexual abuse from R1 by LPN-A on 9/4/20. RN-A stated NA-A and NA-B came up to her and advised her they were walking R1 to her room. R1 was shaking. R1 found out LPN-A was on duty and the staff wanted to make sure it was ok, and requested RN-A speak to R1. RN-A advised NA-A and NA-B she would speak to R1 as soon as she passed her medications. NA-A and NA-B followed up again. RN-A was almost finished with medication pass, and would be there shortly. RN-A had never met R1 before as she is an occasional staff member. On that day of 9/4/20, she was working in the back half of the facility. R1 reported she "just didn't like way things went. He [LPN-A] gives me the creeps". She couldn't recall what day the incident occurred, but identified it was about 2:00 a.m.. or 3:00 a.m. R1 reported her O2 would come off and fall on floor occasionally during the night. LPN-A opened her door, came in, saw it, and picked it up. He said it

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F 600	Continued From page 12 was wet, then advised R1 the floor was wet. Without notice, LPN-A put his hand underneath her covers. That made R1 "creep out". LPN-A took his finger and was "touching inside her brief. RN-A asked her what she would like her to do about him. R1 said he wiped a spot by the bathroom door towards edge of bed. R1 denied being wet. R1 denied penetration, and stated he just left. RN-A assured R1 her concerns would be forwarded. R1 also advised RN-A she had been molested as a child and it felt "just like that". RN-A had not included that in her written report as R1 seemed embarrassed about her past molestation. RN-A had not performed an assessment or started an investigation. RN-A stated she called the DON right away for instruction on how to proceed. The DON had advised RN-A to write a report and see if there was nay further information R1 had on the allegations. The DON had not suspended LPN-A to her knowledge. The DON had called back to the facility after she had spoken with her, but she had not talked to RN-A. The DON spoke to LPN-A. RN-A had never been educated on filing a report to the SA, nor reporting a suspicion of a crime to the police. RN-A looks for direction from the DON and does what she is told. Since RN-A was an occasional staff person, she had not worked for a while prior to 9/4/20. Upon arriving to work that day, she was handed the policy on reporting, advised to read through it and ask if she had questions. RN-A had made no attempt to physically examine R1 on 9/4/20 after allegations of sexual abuse had been made. Review of the 9/4/20, incident report written by RN-A identified R1 advised NA-A and NA-B, she did not want LPN-A in her room. Staff asked RN-A to speak with her. R1 advised RN-a LPN-A	F 600		

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F 600	Continued From page 13 was inappropriately touching her one time but was unable to give a date. LPN-A had come into her room. R1 was unsure why LPN-A had entered her room. R1's nasal cannula had come off and was on the floor. LPN-A picked it and it was wet. R1 advised she felt it was wet from condensation (from humidified oxygen). LPN-A had picked up her bedspread and started moving his hand along her "butt". LPN-A had not advised R1 what he was doing. She requested he not enter her room. Interview and document review on 9/15/20 at 9:43 a.m., with the SW identified the DON never came to the facility on 9/4/20, after being made aware of the incident. On 9/8/20, the SW arrived for work and saw RN-A's written report. She immediately went to the administrator (A) and advised her this was a reportable incident. In review of the staffing schedule leading up to 9/4/20, it was identified LPN-A's last scheduled shifts were 9/3/20 and 8/31/20. LPN-A. R1 would not have seen LPN-A arrive for that shift on 9/3/20, as she would have been in bed, and the incident was reported to occur the last weekend shift time-frame he worked before 9/4/20. The SW agreed the incident would have most have likely occurred on 8/31/20. The SW was in charge of the investigation, which was still ongoing. She had plans to submit the 5 day report to the SA that day. The SW concluded she couldn't prove the allegation likely occur. The SW could not corroborate there was actual urine on the floor. LPN-A advised her the location of the urine was indeed at the end of the bed by R1's feet and not directly below where her bottom was. R1 was "definitely upset about it". The facility wanted to ensure LPN-A had not worked with R1 again. R1 was visibly upset, not crying, but anxious SW reported when she recalled her interview with R1.	F 600		

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F 600	Continued From page 14 The SW believed, "what went wrong was he should have told her what he was doing". In reviewing the location of the fluid found on the floor, the SW agreed, there was no way R1's urine could have deposited at the foot of her bed, rather than directly below her bottom located in the middle of the bed, approximately over 2 feet away. The SW identified the only staff that were allowed to make reports the to SA were herself, the DON and administrator. She also agreed R1 wearing a brief would have limited deposits of urine on the floor and would have saturated R1's bed first. She agreed R1 made no mention of her bedding being wet. R1 also claimed LPN-A had not touched her brief, but was touching her buttocks. The SW agreed, R1's accounts her buttocks was being stroked by LPN-A's fingers would be inconsistent if her underwear were pulled away from her body to feel a brief. The SW also agreed R1 had been independent to toilet and there was no need to physically check her for incontinence. The SW agreed the DON should have immediately suspended LPN-A upon hearing the allegation and reported to the SA. Facility procedures indicated only the SW, admin or the DON could submit a report to the SA. No other staff were allowed to submit reports of suspicions of a crime. Interview on 9/15/20 at 10:20 a.m. with nurse practitioner (NP)-A identified she was unaware of R1's allegation of sexual abuse. The SW had called her, only to ask for the medical director (MD) number last wed. She was on call on 9/4/20 covering nights and weekends. NP-A rounded at the facility on 9/8/20, and was not notified about the allegations at that time either. She would expect the facility follow all policies and procedures and notify a residents provider when	F 600		

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F 600	Continued From page 15 any allegation of abuse or neglect is made. NP-A was made aware of the interviews and events surrounding the allegations. NP-A expected the facility keep the resident safe and suspend any staff until an investigation was completed. R1 had improved in the ability to care for herself and could walk independently, toilet independently, was fully cognitive, and was set to go home in the next few days. Interview on 9/15/20 at 10:53 a.m., with the DON identified she had received a call on 9/4/20 at approximately 10:00 p.m., RN-A had called her and advised R1 wanted to file a complaint against LPN-A. The DON stated RN-A offered no other information and she had not asked. The DON advised RN-A to find out what prompted such a complaint and to call her back. After approximately 15 minutes, the DON called the facility. LPN-A answered the phone. The DON asked him if he "did anything inappropriate" as R1 wanted to file a complaint against him. LPN_A denied any wrongdoing, but did advise the DON of the incident in question and stated he had done nothing wrong and advised her. The reason she asked LPN-A if he had done done anything inappropriate as he had been accused by R3 of being "gruff" with her with allegations "He looked at my vagina". The DON had filed a report but felt after investigation it was unsubstantiated as LPN-A had been providing personal cares and would "have to look" at R3's private parts. The DON agreed she had knowingly disclosed the alleged victim (R1)'s identity to LPN-A. The DON was satisfied with LPN-A's answer of no wrongdoing and stated he was not allowed to provide cares to R1 unless he was accompanied by another staff. The DON agreed, advising LPN-A of the alleged victims identity and not	F 600		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 16 immediately suspending LPN-A placed R1 and other residents at risk for further abuse or retaliation. The DON failed to begin an investigation immediately and had not returned to the facility until 9/8/20. At that time, she was alerted to RN-A's written report. LPN-A was suspended pending the facilities investigation. The DON agreed her resolution and actions to prevent abuse and failing to follow facility policy put all residents at risk. Interview on 9/15/20 at 12:27 p.m. with the MD identified he had not been made aware of the incident until approximately 9/8/20. He was told by the facility R1 reported LPN-A felt her bottom, maybe she had not liked that and was found very upset. MD had not known "much more". MD was unaware LPN-A was notified of R1's identity by the DON, nor that LPN-A had not been suspended immediately, or that no investigation was immediately performed upon identifying the allegation. The MD agreed the facility failed to keep R1 and all other 44 residents safe from retaliation or potential further abuse. He also agreed LPN-A should have been suspended, policies implemented, and an investigation should have been immediately started. Interview on 9/15/20 at 2:45 p.m. with the SW identified she had not called local police for suspicion of a crime but would do so right away. The SW had reported the incident to the MN Board of Nursing. Review of the 9/4/20, Reporting Abuse to Facility Management policy identified it was the responsibility of employees, consultants, physicians, family members, visitors, etc, to promptly report any incident of suspected abuse.	F 600		

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F 600	Continued From page 17 All allegations were to be reported and thoroughly investigated. All reports made were to be made without fear or retaliation from facility or its staff. Reports were to be given to the DON. In her absence, reports were to be made the the charge nurse. Staff members shall not knowingly fail to report an incident or offense, screen reports, or withhold information from reporting agencies. If incidents were discovered after hours (8:00 a.m. to 5:00 p.m.), the admin or DON must be called at home and informed of the incident. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Employees accused of abuse were to be suspended immediately pending the outcome of the investigation. For reports of physical or sexual abuse, a thorough examination was to be performed by licensed nurses. An immediate investigation was to be made and a copy provided to the administrator. Review of the 9/4/20, Abuse Investigations policy identified all reports of abuse were to be promptly reported and thoroughly investigated by the facility immediately but no later than 2 hrs after the allegation. The Ombudsman was to be notified and offered to participate in the investigation. The Ombudsman was to be notified of results of the investigation. Employees were to be suspended immediately. The administrator was to provide a written report of the results to the SA, local police. medical director and others within 5 days of the incident. There was no mention suspicions of a crime were to be reported immediately to local police, the SA, and any other licensing boards immediately but not later than 2 hours. There was also no mention investigations were to begin immediately following an accusation of abuse.	F 600		

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F 600	Continued From page 18 The immediacy was removed when it could be verified the facility took steps to ensure staff were appropriately trained and re-educated to all abuse policies for identifying, reporting, and protecting residents, and implemented an on-call system with management assigned to specific days 24/7, to ensure reports to the SA and all other appropriate entities were made, interventions implemented to keep residents safe, and investigations begun.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		10/27/20

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F 609	Continued From page 19 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 observation, interview and document review, the facility failed to ensure an allegation of sexual assault was reported immediately but no later than 2 hours, for 1 of 1 resident (R1) to the State Agency and local police. Findings include: Review of the 9/8/20 report filed to the State Agency identified the social worker (SW) filed a report identifying the director of nursing (DON) was notified on 9/4/20 of inappropriate touching by licensed practical nurse (LPN)-A to R1. R1 advised staff she had not wanted LPN-A in her room. R1 alleged LPN-A, at an unknown date, had come into R1's room during the overnight hours and picked up R1's nasal cannula off the floor. LPN-A advised R1 there was fluid directly under the nasal cannula. R1 advised LPN-A it was from the condensation from humidified oxygen (O2). LPN-A picked up R1's bedding as R1 was laying in bed, and "moved his hands along her bottom". LPN-A had not advised R1 he was going to check her for alleged incontinence. Action taken by facility was identified as the DON advised LPN-A not to go into R1's room unless there was another staff person present. LPN-A was suspended per report on 9/8/20 pending an investigation. There was no mention the facility had reported the allegation to local police. Review of the facility's investigation notes, which began on 9/8/20 per the social worker, identified	F 609	R1 had a risk management incident created 9-8-20. The MD was notified on 9-9-20. the Police were called on 9-15-20. Her vulnerable adult care plan was reviewed and updated and her preferences were reviewed and included and updated. Social Services met with R1 on 9-8-20, 9-9-20 and 9-10-20. MD was contacted to review resident request for external foley catheter. R1 was discharged on 9-22-20. All residents vulnerable adult care plans and preferences were reviewed and updated as needed. The Administrator and DON were in-serviced on abuse reporting, how to make a report in the SA portal, keeping resident complaints anonymous and suspension of employee/s upon suspicion of an allegation. The Administrator, Director of Nursing, ADON and Social Service Director all have access to the reporting platform and will be responsible for reporting allegations of abuse 24/7. Investigations with allegations of abuse will begin immediately. An on-call schedule was implemented on 9-28-20 on who to report to with Any Allegation of abuse and posted at each nurses station by the phone. This schedule will be updated weekly.	

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F 609	Continued From page 20 R1 advised (RN-A) on 9/4/20 at 10:10 p.m. she does not want a male care giver. LPN-A (no date or time) stated he came to work on 9/4/20 at 8:00 p.m. Over a week ago (unsure of date and time), the nurse aide on duty that night of the incident, was on break. R1 had reportedly put her call light on. LPN-A stated he answered it. LPN-A asked R1 what she needed. R1 stated she wanted cold water. LPN-A went to retrieve the water and upon return, noted a puddle or urine on the floor. LPN-A gave R1 her water and was trying to figure out where it came from. He lifted R1's cover slightly to check her bed. LPN-A advised R1 he was trying to figure out where the urine came from. LPN-A patted the bed. R1 had a "funny look on her face". LPN-A immediately put the covers down and cleaned up the floor. The notes identified R1 frequently refused to be changed and voids in her bed. "there was no inappropriate contact". We (facility staff) will care plan "no male caregivers. If he (LPN-A) needs to give medication or attend to medical tx [treatment], male nurses will take another female staff with them into the room". LPN-A was notified of his suspension on 9/8/20. Further investigation notes identified LPN-A also remarked when he finished cleaning up R1's floor, he and LPN-A were both "joking" when he left the room. On 9/8/20 at 8:35 a.m., R1 was interviewed by the SW. Notes of that interview identified R1 was outside smoking the evening of 9/4/20 and saw LPN-A report to work. R1 advised NA-A and NA-B not to let him come into her room since she felt uncomfortable. R1 was unclear on when the incident of inappropriate contact had occurred, but it was before 9/4/20. LPN-A had entered her room during the night, picked up her nasal cannula and said it was wet. R1 advised	F 609	Full time facility staff were in-serviced on 9-15-20 and 9-16-20 on the facility policy for reporting abuse with the emphasis of reporting incidents immediately. An All Staff meeting will be held on 10-26-20 to review the facility abuse policy with emphasis on when Law Enforcement, MD, Primary Provider, Ombudsman and guardian will be notified. New employees will receive abuse education during their orientation period and will continue annually. Audits on reporting abuse allegations timely, facility notification posting of on-call staff for reporting will begin 2x week for 2 weeks, weekly x3 weeks then monthly x1 year. Audits will be taken to QAPI by Administrator monthly x3 months for oversight and to ensure compliance. Responsible Party: Director of Nursing or Designee	

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F 609	Continued From page 21 LPN-A it was wet from condensation. LPN-A left to get new tubing. R1 stated she was lying on her side with her back facing the doorway. When LPN-A returned, he touched her bottom inside her brief. R1 declared she had not used her call light to summon LPN-A that night. R1 declared no other staff has ever checked her for incontinence in that manner. R1 reported to the SW she felt safe. All staff were good to her except LPN-A. Both NA-A and NA-B were interviewed on 9/8/20. NA-B stated on the night of 9/4/20, R1 was outside smoking, came inside and was visibly shaking. NA-B asked if she was ok to which R1 replied "Not really. Seeing [LPN-A] makes me nervous". Both NA's took R1 to her room. R1 reported she had woken up to LPN-A checking her brief by sticking his finger in the back of her brief without telling her. R1 denied she had been wet. After talking to RN-A, NA-A and NA-B were advised LPN-A was not allowed in R1's room. Other staff were interviewed, but had no knowledge of the incident. Other residents were interviewed for safety and had no issues or concerns with staff. The Ombudsman was notified on 9/8/20 and the medical director was identified as being notified on 9/9/20. It was indicated in the report, after review of interviews, the facility identified "it was our belief LPN-A was not abusive, nor had intent of abuse. We believed he failed at communication..". Corrective action identified were male staff were to be accompanied by a female staff per resident request. Before returning to work, LPN-A would be inserviced on the importance of explaining to residents what he is doing before hand. LPN-A was to have one-on-one supervision for 1 week. RN-A was to be inserviced on 9/14/20 on the importance of getting all the facts first hand and reporting timely. The facility was to monitor its	F 609		

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F 609	Continued From page 22 corrective actions. There was no mention facility management had identified they failed to report the suspicion of a crime to the SA and law enforcement within 2 hours of the allegation. R1's 8/17/20, admission Minimum Data Set (MDS) assessment identified she was fully cognitive and required extensive assist of 1 staff for toileting. R1's 8/18/20, progress notes identified R1 was admitted to the facility to receive rehabilitative services related to back pain and weakness and had pans to return home. Her admitting diagnoses were low back pain, muscle weakness, chronic obstructive pulmonary disease (COPD). Interview on 9/14/20, with LPN-A identified the above incident occurred about a week ago to his knowledge. LPN-A was charge nurse on the night of the incident. R1 had put her call light on at approximately 3:00 a.m.. R1 had lost her oxygen tubing and it was laying on the floor in a puddle at the end of her bed by R1's feet. LPN-A left the room to get R1 new O2 tubing. LPN-A then proceeded to hook up R1's new tubing. R1 was laying in bed on her side, facing the wall, away from her door. R1 had a fluffy blanket. LPN-A advised her he was cleaning up the liquid fond underneath her O2 tubing. R1's blanket kept falling into the liquid on the floor as he was trying to clean it up. R1 was "uncomfortable with me at that point". LPN-A proceeded to touch R1's incontinence pad. LPN-A acknowledged he had not advised R1 what he was going to check her brief. LPN-A asked R1 if she wanted another staff to help her clean up, but she refused. LPN-A then stated he made a "joke" to which R1 laughed and	F 609		

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F 609	Continued From page 23	F 609		

he left the room. R1 had never made concerns known about not receiving assistance from male staff members. LPN-A was unsure how R1 could have leaked urine by the foot of her bed, when the area directly below her bottom, in the middle of the bed, was dry. R1 had been known to refuse cares. In hindsight, he should have been "more clear" during cares. On 9/4/20, registered nurse (RN)-A had advised him he was not to go into R1's room at any time. RN-A advised LPN-A he had touched R1 inappropriately. RN-A was going to call the DON and alert her to R1's allegations. The DON called back and spoke with LPN-A. He was told to keep his distance from R1 and have another staff member give R1 her medications. He was suspended on 9/8/20 pending an investigation. He had worked 9/4/20, 9/5/20, and 9/6/20. LPN-A had come to the facility on 9/14/20 as he was turning in his resignation effective 9/19/20. He was to work his upcoming 3 scheduled shifts on 9/17/20 through 9/19/20. LPN-A was resigning over the allegations.

Review of LPN-A's August and September, 2020, staff schedules and time clock entries identified LPN-A was scheduled to work overnight shifts on 8/27/20, 8/31/20, 9/3/20, 9/4/20, 9/5/20, and 9/6/20.. LPN-A's timecard identified he worked on:
1) 8/27/20, beginning at 6:00 p.m. until 6:46 a.m.
2) 8/31/20, beginning at 9:58 p.m. until 6:51 a.m.
3) 9/3/20, beginning at 10:01 p.m. until 6:40 a.m.
4) 9/4/20, beginning at 8:03 p.m. until 6:46 a.m.
5) 9/5/20, beginning at 6:02 p.m. through 6:28 a.m.,
6) 9/6/20 beginning at 5:58 p.m. and finishing at 7:09 a.m.

Review of LPN-A's employee file identified a

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F 609	Continued From page 24 performance review dated 9/14/20, 3 resident complaints were identified on 5/5/20, 6/22/20, and 9/4/20. The review identified LPN-A was flexible, worked both units and preferred working his night shift. LPN-A was identified having conflicts with some residents. LPN-A was to watch his tone as he had made "hurtful" statements without realizing it. It was identified he needed to "explain what you are doing, before you do it." LPN-A had a background check performed 6/3/20, which identified LPN-A had no criminal history reported. LPN-A was hired 11/18/19. There was no previous background check identified in his file. LPN-A had concern and problem resolution coaching's in his file. With regard to R3's complaint of LPN-A looking at her vagina, it was identified by the facility LPN-A had told R3 "You old people, its all in your head and you imagine things." R3 reported to management he made her "skin crawl" and was rude when other staff weren't around. He told her in a "creepy voice... I'm back.." when he returned to work. No disciplinary actions were included in LPN-A's file. Interview on 9/14/20 with nursing assistant (NA)-A identified she was made aware of the incident on 9/4/20 by R1. R1 had reported to NA-A and NA-B she had seen LPN-A report for his shift that day at approximately 8:00 p.m.. R1 was outside. Staff noted R1 was afraid to come in and was shaking. R1 stated "I don't want that [expletive] working with me. R1 elaborated LPN-A had made he feel uncomfortable the last time he worked. LPN-A came into her room during the incident (unknown date) and started "poking" at her bottom. R1 wears an incontinence brief. R1 stated LPN-A was touching her inappropriately and did not know what to say to LPN-A at that time. R1 advised she was shocked and scared. R1 had not	F 609		

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F 609	Continued From page 25 told anyone about the incident before 9/4/20, and she was afraid. R1 began to cry and would not go into any further detail with NA-A or NA-B. Both NA-A and NA-B left R1's room and advised RN-A immediately. RN-A went into R1's room and spoke to her about the incident. RN-A exited the room and looked to be visibly upset by the allegations R1 had advised her of. RN-A was witnessed telling LPN-A he was not to go into R1's room. R1 had never had any concerns with male staff. There was another male staff on the floor and R1 had no concerns with that male staff member. Interview on 9/14/20 at 4:41 p.m. with NA-B identified R1 was a smoker and was outside the evening of 9/4/20. LPN-A had come in early, around 8:00 p.m. that day for his shift. NA-A and NA-B had noticed R1 was outside and rang the doorbell to come back into the facility. R1 was shaking and visibly upset. "She was petrified". NA-A and NA-B proceeded to ask R1 what the matter was. She was reluctant to say. R1 proceeded to tell the staff LPN-A had come into her room the other might when he worked. R1 advised LPN-A was checking her to see if she was wet. He stuck his fingers in her brief and touched her inappropriately. R1 takes care of herself and requires no assistance to toilet or put herself to bed etc. She only needed help when she was first admitted. R1 was expected to discharge soon. NA- A and NA-B left to find RN-A and advise her of the need to speak with R1 as soon as possible. RN-A was giving meds, and as soon as she was done, she would speak with R1. RN-A finished her medication pass and went to speak with R1 in her room. When RN-A came out of R1's room, she went to LPN-A who was working on that wing and advised him he was not	F 609		

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Continued From page 26

to go into R1's room. Today on 9/14/20, when LPN-A came to work, R1 saw him come in. She began shaking. R1 kept watching the door to see if LPN-A was coming onto shift.

Observation and interview on 9/14/20 at 5:00 p.m., with R1 identified LPN-A works overnight shifts. R1 goes to bed early. On the date of the incident which R1 recalled as the last time he worked but was unsure of that date. R 1 stated LPN-A usually works weekends. It would have been the previous weekend night shifts to 9/4/20. R1 is awake and routinely sees the night shift report to work. R1 pointed to her calendar and identified the incident likely occurred between the dates of 8/28/20 and 8/31/20 which was the last scheduled weekend she saw him. LPN-A came into R1's room. She was sound asleep but woke up startled when she realized R1 was in her room. R1 wore O2 at night. Occasionally this falls off. Her tubing was laying on the floor at the foot of her bed. LPN-A picked up the tubing, gave it to R1 and she advised him it was wet. LPN_A stated it was wet on the floor where her tubing had been. LPN-A then grabbed wet the tubing, left the room, and came back with new O2 tubing. LPN-A advised her the spot of liquid on the floor at her feet "looked like pee". R1 advised him that was condensation from her O2 tubing with humidified oxygen. R1 stated she had not felt wet in her brief. LPN-A showed her the rag after he wiped up the liquid on the floor and showed her it was dirty. R1 slept with the over-bed lights on at all times and would lay on hr left side with her back away from the door, facing the wall. All of a sudden, R1 felt her covers being lifted and LPN-A was poking his fingers on her [expletive]. R1 stated she was" terrified". LPN-A had not said anything. He would start feeling her bottom, then

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F 609	Continued From page 27 stop. She heard clicking noises but was unsure what they were coming from. She thought it sounded like a pen light nurses use, but never saw any flash or light of any kind. R1 denied LPN-A had penetrated her in any way. "His finger was on my butt going up and down." R1 stated she had never been touched like that before. LPN-A was not touching her brief. R1 toilets herself and had no reason for LPN-A to attempt to check her brief for wetness. R1 identified she was "so scared" and "hadn ' t had the nerve to talk". LPN-A finally said "Do you need to be changed?". R1 was able to say "No". LPN-A replied to her "Alright then" and left her room. R1 stated LPN-A was very intentionally touching her buttocks and was not in any way on her brief. No staff had ever touched her that way before. R1 has never had any concerns with any male staff at any health facility. R1 elaborated the wet spot on the floor was by her feet, not on the floor directly below her bottom. R1 was scared that night and again today on 9/14/20, when she saw LPN-A arrive for work. R1 was afraid LPN-A was coming back to work. R1 stated when she saw LPN-A today arrive for work, she started shaking, and got a "creepy" feeling in her stomach with nausea. R1 does not feel safe around LPN-A. "I can talk! Others [residents] can't". R1 was going home soon and walked independently with cares. Observations during interview of R1 identified was visibly shaken was teary eyed and expressed anger throughout the interview. Interview on 9/14/20 at 6:06 p.m. with RN-A identified she was made aware of the allegation of sexual abuse from R1 by LPN-A on 9/4/20. RN-A stated NA-A and NA-B came up to her and advised her they were walking R1 to her room. R1 was shaking. R1 found out LPN-A was on duty	F 609		

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F 609	Continued From page 28 and the staff wanted to make sure it was ok, and requested RN-A speak to R1. RN-A advised NA-A and NA-B she would speak to R1 as soon as she passed her medications. NA-A and NA-B followed up again. RN-A was almost finished with medication pass, and would be there shortly. RN-A had never met R1 before as she is an occasional staff member. On that day of 9/4/20, she was working in the back half of the facility. R1 reported she "just didn't like way things went. He [LPN-A] gives me the creeps". She couldn't recall what day the incident occurred, but identified it was about 2:00 a.m.. or 3:00 a.m. R1 reported her O2 would come off and fall on floor occasionally during the night. LPN-A opened her door, came in, saw it, and picked it up. He said it was wet, then advised R1 the floor was wet. Without notice, LPN-A put his hand underneath her covers. That made R1 "creep out". LPN-A took his finger and was "touching inside her brief. RN-A asked her what she would like her to do about him. R1 said he wiped a spot by the bathroom door towards edge of bed. R1 denied being wet. R1 denied penetration, and stated he just left. RN-A assured R1 her concerns would be forwarded. R1 also advised RN-A she had been molested as a child and it felt "just like that". RN-A had not included that in her written report as R1 seemed embarrassed about her past molestation. RN-A had not performed an assessment or started an investigation. RN-A stated she called the DON right away for instruction on how to proceed. The DON had advised RN-A to write a report and see if there was nay further information R1 had on the allegations. The DON had not suspended LPN-A to her knowledge. The DON had called back to the facility after she had spoken with her, but she had not talked to RN-A. The DON spoke to	F 609		

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LPN-A. RN-A had never been educated on filing a report to the SA, nor reporting a suspicion of a crime to the police. RN-A looks for direction from the DON and does what she is told. Since RN-A was an occasional staff person and had not worked for a while prior to 9/4/20. Upon arriving to work that day, she was handed the policy on reporting, advised to read through it and ask if she had questions. RN-A had made no attempt to physically examine R1 on 9/4/20 after allegations of sexual abuse had been made.

Review of the 9/4/20, incident report written by RN-A identified R1 advised NA-A and NA-B, she did not want LPN-A in her room. Staff asked RN-A to speak with her. R1 advised RN-a LPN-A was inappropriately touching her one time but was unable to give a date. LPN-A had come into her room. R1 was unsure why LPN-A had entered her room. R1's nasal cannula had come off and was on the floor. LPN-A picked it and it was wet. R1 advised she felt it was wet from condensation (from humidified oxygen). LPN-A had picked up her bedspread and started moving his hand along her "butt". LPN-A had not advised R1 what he was doing. She requested he not enter her room.

Interview and document review on 9/15/20 at 9:43 a.m., with the SW identified the DON never came to the facility on 9/4/20, after being made aware of the incident. On 9/8/20, the SW arrived for work and saw RN-A's written report. She immediately went to the administrator (A) and advised her this was a reportable incident. In review of the staffing schedule leading up to 9/4/20, it was identified LPN-A's last scheduled shifts were 9/3/20 and 8/31/20. LPN-A. R1 would not have seen LPN-A arrive for that shift on 9/3/20, as she would have been in bed, and the

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F 609	Continued From page 30 incident was reported to occur the last weekend shift time-frame he worked before 9/4/20. The SW agreed the incident would have most have likely occurred on 8/31/20. The SW was in charge of the investigation, which was still ongoing. She had plans to submit the 5 day report to the SA that day. The SW concluded she couldn ' t prove the allegation likely occur. The SW could not corroborate there was actual urine on the floor. LPN-A advised her the location of the urine was indeed at the end of the bed by R1's feet and not directly below where her bottom was. R1 was "definitely upset about it". The facility wanted to ensure LPN-A had not worked with R1 again. R1 was visibly upset, not crying, but anxious SW reported when she recalled her interview with R1. The SW believed, "what went wrong was he should have told her what he was doing". In reviewing the location of the fluid found on the floor, the SW agreed, there was no way R1's urine could have deposited at the foot of her bed, rather than directly below her bottom located in the middle of the bed, approximately over 2 feet away. The SW identified the only staff that were allowed to make reports the to SA were herself, the DON and administrator. She also agreed R1 wearing a brief would have limited deposits of urine on the floor and would have saturated R1's bed first. She agreed R1 made no mention of her bedding being wet. R1 also claimed LPN-A had not touched her brief, but was touching her buttocks. The SW agreed, R1's accounts her buttocks was being stroked by LPN-A's fingers would be inconsistent if her underwear were pulled away from her body to feel a brief. The SW also agreed R1 had been independent to toilet and there was no need to physically check her for incontinence. The SW agreed the DON should have immediately suspended LPN-A upon	F 609		

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hearing the allegation and reported to the SA. Facility procedures indicated only the SW, admin or the DON could submit a report to the SA. No other staff were allowed to submit reports of suspicions of a crime.

Interview on 9/15/20 at 10:20 a.m. with nurse practitioner (NP)-A identified she was unaware of R1's allegation of sexual abuse. The SW had called her, only to ask for the medical director (MD) number last wed. She was on call on 9/4/20 covering nights and weekends. NP-A rounded at the facility on 9/8/20, and was not notified about the allegations at that time either. She would expect the facility follow all policies and procedures and notify a residents provider when any allegation of abuse or neglect is made. NP-A was made aware of the interviews and events surrounding the allegations. NP-A expected the facility keep the resident safe and suspend any staff until an investigation was completed. R1 had improved in the ability to care for herself and could walk independently, toilet independently, was fully cognitive, and was set to go home in the next few days.

Interview on 9/15/20 at 10:53 a.m., with the DON identified she had received a call on 9/4/20 at approximately 10:00 p.m., RN-A had called her and advised R1 wanted to file a complaint against LPN-A. The DON stated RN-A offered no other information and she had not asked. The DON advised RN-A to find out what prompted such a complaint and to call her back. After approximately 15 minutes, the DON called the facility. LPN-A answered the phone. The DON asked him if he "did anything inappropriate" as R1 wanted to file a complaint against him. LPN_A denied any wrongdoing, but did advise the DON

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F 609	Continued From page 32 of the incident in question and stated he had done nothing wrong and advised her. The reason she asked LPN-A if he had done done anything inappropriate as he had been accused by R3 of being "gruff" with her with allegations "He looked at my vagina". The DON had filed a report but felt after investigation it was unsubstantiated as LPN-A had been providing personal cares and would "have to look" at R3's private parts. The DON agreed she had knowingly disclosed the alleged victim (R!)'s identity to LPN-A. The DON was satisfied with LPN-A's answer of no wrongdoing and stated he was not allowed to provide cares to R1 unless he was accompanied by another staff. The DON agreed, advising LPN-A of the alleged victims identity and not immediately suspending LPN-A placed R1 and other residents at risk for further abuse or retaliation. The DON failed to begin an investigation immediately and had not returned to the facility until 9/8/20. At that time, she was alerted to RN-A's written report. LPN-A was suspended pending the facilities investigation. The DON agreed her resolution and actions to prevent abuse and failing to follow facility policy put all residents at risk. Interview on 9/15/20 at 12:27 p.m. with the MD identified he had not been made aware of the incident until approximately 9/8/20. He was told by the facility R1 reported LPN-A felt her bottom, maybe she had not liked that and was found very upset. MD had not known "much more". MD was unaware LPN-A was notified of R1's identity by the DON, nor that LPN-A had not been suspended immediately, or that no investigation was immediately performed upon identifying the allegation. The MD agreed the facility failed to keep R1 and all other 44 residents safe from	F 609		

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F 609	Continued From page 33 retaliation or potential further abuse. He also agreed LPN-A should have been suspended, policies implemented, and an investigation should have been immediately started. Interview on 9/15/20 at 2:45 p.m. with the SW identified she had not called local police for suspicion of a crime but would do so right away. The SW had reported the incident to the MN Board of Nursing. Review of the 9/4/20, Reporting Abuse to Facility Management policy identified it was the responsibility of employees, consultants, physicians, family members, visitors, etc, to promptly report any incident of suspected abuse. All allegations were to be reported and thoroughly investigated. All reports made were to be made without fear or retaliation from facility or its staff. Reports were to be given to the DON. In her absence, reports were to be made the the charge nurse. Staff members shall not knowingly fail to report an incident or offense, screen reports, or withhold information from reporting agencies. If incidents were discovered after hours (8:00 a.m. to 5:00 p.m.), the admin or DON must be called at home and informed of the incident. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Employees accused of abuse were to be suspended immediately pending the outcome of the investigation. For reports of physical or sexual abuse, a thorough examination was to be performed by licensed nurses. An immediate investigation was to be made and a copy provided to the administrator. Review of the 9/4/20, Abuse Investigations policy identified all reports of abuse were to be promptly	F 609		

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F 609	Continued From page 34 reported and thoroughly investigated by the facility immediately but no later than 2 hrs after the allegation. The Ombudsman was to be notified and offered to participate in the investigation. The Ombudsman was to be notified of results of the investigation. Employees were to be suspended immediately. The administrator was to provide a written report of the results to the SA, local police. medical director and others within 5 days of the incident. There was no mention suspicions of a crime were to be reported immediately to local police, the SA, and any other licensing boards immediately but not later than 2 hours. There was also no mention investigations were to begin immediately following an accusation of abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610		10/27/20

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Continued From page 35

by:
Based on observation, interview and document review, the facility failed to immediately begin a thorough investigation, prevent further potential abuse, and implement corrective measures after allegations of sexual abuse were made by 1 of 1 resident (R1) alleging sexual abuse by staff.

Findings include:

Review of the 9/8/20 report filed to the State Agency identified the social worker (SW) filed a report identifying the director of nursing (DON) was notified on 9/4/20 of inappropriate touching by licensed practical nurse (LPN)-A to R1. R1 advised staff she had not wanted LPN-A in her room. R1 alleged LPN-A, at an unknown date, had come into R1's room during the overnight hours and picked up R1's nasal cannula off the floor. LPN-A advised R1 there was fluid directly under the nasal cannula. R1 advised LPN-A it was from the condensation from humidified oxygen (O2). LPN-A picked up R1's bedding as R1 was laying in bed, and "moved his hands along her bottom". LPN-A had not advised R1 he was going to check her for alleged incontinence. Action taken by facility was identified as the DON advised LPN-A not to go into R1's room unless there was another staff person present. LPN-A was suspended per report on 9/7/20 pending an investigation.

Review of the facility's investigation notes, which began on 9/8/20 per the social worker, identified R1 advised (RN-A) on 9/4/20 at 10:10 p.m. she does not want a male care giver. LPN-A (no date or time) stated he came to work on 9/4/20 at 8:00 p.m. Over a week ago (unsure of date and time), the nurse aide on duty that night of the incident,

F 610

R1 had a risk management incident created 9-8-20. The MD was notified 9-9-20. The Police were called on 9-15-20. R1 had her vulnerable adult care plan reviewed and updated. Social Services met with R1 on 9-8-20, 9-9-20 and 9-10-20.

All resident who could communicate, were interviewed and no other reports of abuse were voiced. For residents who were unable to communicate, their families were called. This notification will be included in the resident's EMR.

The Administrator, DON and Social Services were in-serviced on thoroughly investigating abuse allegations and timeliness of investigations. This team was in-serviced on abuse reporting, how to make a report in the SA portal, keeping resident complaints anonymous and suspension of employee/s upon suspicion of an allegation. The Administrator, Director of Nursing, ADON and Social Service Director all have access to the reporting platform and will be responsible for reporting allegations of abuse 24/7. Investigations with allegations of abuse will begin immediately. An on-call schedule was implemented on 9-28-20 on who to report to with any Allegation of abuse and posted at each nurses station by the phone. This schedule will be updated weekly.

Full time facility staff were in-serviced on 9-15-20 and 9-16-20 on the facility policy

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F 610	Continued From page 36 was on break. R1 had reportedly put her call light on. LPN-A stated he answered it. LPN-A asked R1 what she needed. R1 stated she wanted cold water. LPN-A went to retrieve the water and upon return, noted a puddle or urine on the floor. LPN-A gave R1 her water and was trying to figure out where it came from. He lifted R1's cover slightly to check her bed. LPN-A advised R1 he was trying to figure out where the urine came from. LPN-A patted the bed. R1 had a "funny look on her face". LPN-A immediately put the covers down and cleaned up the floor. The notes identified R1 frequently refused to be changed and voids in her bed. "there was no inappropriate contact". We (facility staff) will care plan "no male caregivers. If he (LPN-A) needs to give medication or attend to medical tx [treatment], male nurses will take another female staff with them into the room". LPN-A was notified of his suspension on 9/8/20. Further investigation notes identified LPN-A also remarked when he finished cleaning up R1's floor, he and LPN-A were both "joking" when he left the room. On 9/8/20 at 8:35 a.m., R1 was interviewed by the SW. Notes of that interview identified R1 was outside smoking the evening of 9/4/20 and saw LPN-A report to work. R1 advised NA-A and NA-B not to let him come into her room since she felt uncomfortable. R1 was unclear on when the incident of inappropriate contact had occurred, but it was before 9/4/20. LPN-A had entered her room during the night, picked up her nasal cannula and said it was wet. R1 advised LPN-A it was wet from condensation. LPN-A left to get new tubing. R1 stated she was lying on her side with her back facing the doorway. When LPN-A returned, he touched her bottom inside her brief. R1 declared she had not used her call light	F 610	for reporting abuse with the emphasis of reporting incidents immediately. An All Staff Meeting will be held on 10-26-20 to review the facility abuse policy with emphasis on when Law Enforcement, MD, Primary Provider, Ombudsman and guardian will be notified. Audits on thoroughly investigating abuse reports and appropriate safety measures are in place and corrective action audits will be 2x week for 2 weeks, weekly x3 weeks then monthly x1 year. Audits will be taken to QAPI by Administrator monthly x3 months for oversight and to ensure compliance. Responsible Party: Social Service Director, Director of Nursing or Designee.	

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F 610	Continued From page 37 to summon LPN-A that night. R1 declared no other staff has ever checked her for incontinence in that manner. R1 reported to the SW she felt safe. All staff were good to her except LPN-A. Both NA-A and NA-B were interviewed on 9/8/20. NA-B stated on the night of 9/4/20, R1 was outside smoking, came inside and was visibly shaking. NA-B asked if she was ok to which R1 replied "Not really. Seeing [LPN-A] makes me nervous". Both NA's took R1 to her room. R1 reported she had woken up to LPN-A checking her brief by sticking his finger in the back of her brief without telling her. R1 denied she had been wet. After talking to RN-A, NA-A and NA-B were advised LPN-A was not allowed in R1's room. Other staff were interviewed, but had no knowledge of the incident. Other residents were interviewed for safety and had no issues or concerns with staff. The Ombudsman was notified on 9/8/20 and the medical director was identified as being notified on 9/9/20. It was indicated in the report, after review of interviews, the facility identified "it was our belief LPN-A was not abusive, nor had intent of abuse. We believed he failed at communication..". Corrective action identified were male staff were to be accompanied by a female staff per resident request. Before returning to work, LPN-A would be inserviced on the importance of explaining to residents what he is doing before hand. LPN-A was to have one-on-one supervision for 1 week. RN-A was to be inserviced on 9/14/20 on the importance of getting all the facts first hand and reporting timely. The facility was to monitor its corrective actions. There was no mention facility management had identified they failed to report the suspicion of a crime to the SA and law enforcement within 2 hours of the allegation. There was also no mention the facility had	F 610		

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identified it failed to follow policies and procedures by immediately beginning and investigation and suspending alleged perpetrators upon notification of an allegation. There was also no mention of appropriate notification to family and or the residents representative, or primary care physician.

R1's 8/17/20, admission Minimum Data Set (MDS) assessment identified she was fully cognitive and required extensive assist of 1 staff for toileting.

R1's 8/18/20, progress notes identified R1 was admitted to the facility to receive rehabilitative services related to back pain and weakness and had pans to return home. Her admitting diagnoses were low back pain, muscle weakness, chronic obstructive pulmonary disease (COPD).

Interview on 9/14/20, with LPN-A identified the above incident occurred about a week ago to his knowledge. LPN-A was charge nurse on the night of the incident. R1 had put her call light on at approximately 3:00 a.m.. R1 had lost her oxygen tubing and it was laying on the floor in a puddle at the end of her bed by R1's feet. LPN-A left the room to get R1 new O2 tubing. LPN-A then proceeded to hook up R1's new tubing. R1 was laying in bed on her side, facing the wall, away from her door. R1 had a fluffy blanket. LPN-A advised her he was cleaning up the liquid fond underneath her O2 tubing. R1's blanket kept falling into the liquid on the floor as he was trying to clean it up. R1 was "uncomfortable with me at that point". LPN-A proceeded to touch R1's incontinence pad. LPN-A acknowledged he had not advised R1 what he was going to check her

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brief. LPN-A asked R1 if she wanted another staff to help her clean up, but she refused. LPN-A then stated he made a "joke" to which R1 laughed and he left the room. R1 had never made concerns known about not receiving assistance from male staff members. LPN-A was unsure how R1 could have leaked urine by the foot of her bed, when the area directly below her bottom, in the middle of the bed, was dry. R1 had been known to refuse cares. In hindsight, he should have been "more clear" during cares. On 9/4/20, registered nurse (RN)-A had advised him he was not to go into R1's room at any time. RN-A advised LPN-A he had touched R1 inappropriately. RN-A was going to call the DON and alert her to R1's allegations. The DON called back and spoke with LPN-A. He was told to keep his distance from R1 and have another staff member give R1 her medications. He was suspended on 9/8/20 pending an investigation. He had worked 9/4/20, 9/5/20, and 9/6/20. LPN-A had come to the facility on 9/14/20 as he was turning in his resignation effective 9/19/20. He was to work his upcoming 3 scheduled shifts on 9/17/20 through 9/19/20. LPN-A was resigning over the allegations.

Review of LPN-A's August and September, 2020, staff schedules and time clock entries identified LPN-A was scheduled to work overnight shifts on 8/27/20, 8/31/20, 9/3/20, 9/4/20, 9/5/20, and 9/6/20.. LPN-A's timecard identified he worked on:
1) 8/27/20, beginning at 6:00 p.m. until 6:46 a.m.
2) 8/31/20, beginning at 9:58 p.m. until 6:51 a.m.
3) 9/3/20, beginning at 10:01 p.m. until 6:40 a.m.
4) 9/4/20, beginning at 8:03 p.m. until 6:46 a.m.
5) 9/5/20, beginning at 6:02 p.m. through 6:28 a.m.,
6) 9/6/20 beginning at 5:58 p.m. and finishing at

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7:09 a.m.

Review of LPN-A's employee file identified a performance review dated 9/14/20. 3 resident complaints were identified on 5/5/20, 6/22/20, and 9/4/20. There was no indication LPN-A received any disciplinary actions or additional training or education following those resident complaints. The review identified LPN-A was flexible, worked both units and preferred working his night shift. LPN-A was identified having conflicts with some residents. LPN-A was to watch his tone as he had made "hurtful" statements without realizing it. It was identified he needed to "explain what you are doing, before you do it." LPN-A had a background check performed 6/3/20, which identified LPN-A had no criminal history reported. LPN-A was hired 11/18/19. There was no previous background check identified in his file. LPN-A had concern and problem resolution coaching's in his file. With regard to R3's complaint of LPN-A looking at her vagina, it was identified by the facility LPN-A had told R3 "You old people, its all in your head and you imagine things." R3 reported to management he made her "skin crawl" and was rude when other staff weren't around. He told her in a "creepy voice... I'm back.." when he returned to work. No disciplinary actions were included in LPN-A's file.

Interview on 9/14/20 with nursing assistant (NA)-A identified she was made aware of the incident on 9/4/20 by R1. R1 had reported to NA-A and NA-B she had seen LPN-A report for his shift that day at approximately 8:00 p.m.. R1 was outside. Staff noted R1 was afraid to come in and was shaking. R1 stated "I don't want that [expletive] working with me. R1 elaborated LPN-A had made he feel uncomfortable the last time he worked. LPN-A

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came into her room during the incident (unknown date) and started "poking" at her bottom. R1 wears an incontinence brief. R1 stated LPN-A was touching her inappropriately and did not know what to say to LPN-A at that time. R1 advised she was shocked and scared. R1 had not told anyone about the incident before 9/4/20, and she was afraid. R1 began to cry and would not go into any further detail with NA-A or NA-B. Both NA-A and NA-B left R1's room and advised RN-A immediately. RN-A went into R1's room and spoke to her about the incident. RN-A exited the room and looked to be visibly upset by the allegations R1 had advised her of. RN-A was witnessed telling LPN-A he was not to go into R1's room. R1 had never had any concerns with male staff. There was another male staff on the floor and R1 had no concerns with that male staff member.

Interview on 9/14/20 at 4:41 p.m. with NA-B identified R1 was a smoker and was outside the evening of 9/4/20. LPN-A had come in early, around 8:00 p.m. that day for his shift. NA-A and NA-B had noticed R1 was outside and rang the doorbell to come back into the facility. R1 was shaking and visibly upset. "She was petrified". NA-A and NA-B proceeded to ask R1 what the matter was. She was reluctant to say. R1 proceeded to tell the staff LPN-A had come into her room the other might when he worked. R1 advised LPN-A was checking her to see if she was wet. He stuck his fingers in her brief and touched her inappropriately. R1 takes care of herself and requires no assistance to toilet or put herself to bed etc. She only needed help when she was first admitted. R1 was expected to discharge soon. NA- A and NA-B left to find RN-A and advise her of the need to speak with R1 as

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F 610	Continued From page 42 soon as possible. RN-A was giving meds, and as soon as she was done, she would speak with R1. RN-A finished her medication pass and went to speak with R1 in her room. When RN-A came out of R1's room, she went to LPN-A who was working on that wing and advised him he was not to go into R1's room. Today on 9/14/20, when LPN-A came to work, R1 saw him come in. She began shaking. R1 kept watching the door to see if LPN-A was coming onto shift. Observation and interview on 9/14/20 at 5:00 p.m., with R1 identified LPN-A works overnight shifts. R1 goes to bed early. On the date of the incident which R1 recalled as the last time he worked but was unsure of that date. R 1 stated LPN-A usually works weekends. It would have been the previous weekend night shifts to 9/4/20. R1 is awake and routinely sees the night shift report to work. R1 pointed to her calendar and identified the incident likely occurred between the dates of 8/28/20 and 8/31/20 which was the last scheduled weekend she saw him. LPN-A came into R1's room. She was sound asleep but woke up startled when she realized R1 was in her room. R1 wore O2 at night. Occasionally this falls off. Her tubing was laying on the floor at the foot of her bed. LPN-A picked up the tubing, gave it to R1 and she advised him it was wet. LPN_A stated it was wet on the floor where her tubing had been. LPN-A then grabbed wet the tubing, left the room, and came back with new O2 tubing. LPN-A advised her the spot of liquid on the floor at her feet "looked like pee". R1 advised him that was condensation from her O2 tubing with humidified oxygen. R1 stated she had not felt wet in her brief. LPN-A showed her the rag after he wiped up the liquid on the floor and showed her it was dirty. R1 slept with the over-bed lights on at all	F 610		

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F 610	Continued From page 43 times and would lay on hr left side with her back away from the door, facing the wall. All of a sudden, R1 felt her covers being lifted and LPN-A was poking his fingers on her [expletive]. R1 stated she was" terrified". LPN-A had not said anything. He would start feeling her bottom, then stop. She heard clicking noises but was unsure what they were coming from. She thought it sounded like a pen light nurses use, but never saw any flash or light of any kind. R1 denied LPN-A had penetrated her in any way. His finger was on my butt check going up and down. R1 stated she had never been touched like that before. LPN-A was not touching her brief. R1 toilets herself and had no reason for LPN-A to attempt to check her brief for wetness. R1 identified she was "so scared" and "hadn ' t had the nerve to talk". LPN-A finally said "Do you need to be changed?". R1 was able to say "No". LPN-A replied to her "Alright then" and left her room. R1 stated LPN-A was very intentionally touching her buttocks and was not in any way on her brief. No staff had ever touched her that way before. R1 has never had any concerns with any male staff at any health facility. R1 elaborated the wet spot on the floor was by her feet, not on the floor directly below her bottom. R1 was scared that night and again today on 9/14/20, when she saw LPN-A arrive for work. R1 was afraid LPN-A was coming back to work. R1 stated when she saw LPN-A today arrive for work, she started shaking, and got a "creepy" feeling in her stomach with nausea. R1 does not feel safe around LPN-A. "I can talk! Others [residents] can't". R1 was going home soon and walked independently with cares. Observations during interview of R1 identified was visibly shaken was teary eyed and expressed anger throughout the interview.	F 610		

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F 610	Continued From page 44 Interview on 9/14/20 at 6:06 p.m. with RN-A identified she was made aware of the allegation of sexual abuse from R1 by LPN-A on 9/4/20. RN-A stated NA-A and NA-B came up to her and advised her they were walking R1 to her room. R1 was shaking. R1 found out LPN-A was on duty and the staff wanted to make sure it was ok, and requested RN-A speak to R1. RN-A advised NA-A and NA-B she would speak to R1 as soon as she passed her medications. NA-A and NA-B followed up again. RN-A was almost finished with medication pass, and would be there shortly. RN-A had never met R1 before as she is an occasional staff member. On that day of 9/4/20, she was working in the back half of the facility. R1 reported she "just didn't like way things went. He [LPN-A] gives me the creeps". She couldn't recall what day the incident occurred, but identified it was about 2:00 a.m.. or 3:00 a.m. R1 reported her O2 would come off and fall on floor occasionally during the night. LPN-A opened her door, came in, saw it, and picked it up. He said it was wet, then advised R1 the floor was wet. Without notice, LPN-A put his hand underneath her covers. That made R1 "creep out". LPN-A took his finger and was "touching inside her brief. RN-A asked her what she would like her to do about him. R1 said he wiped a spot by the bathroom door towards edge of bed. R1 denied being wet. R1 denied penetration, and stated he just left. RN-A assured R1 her concerns would be forwarded. R1 also advised RN-A she had been molested as a child and it felt "just like that". RN-A had not included that in her written report as R1 seemed embarrassed about her past molestation. RN-A had not performed an assessment or started an investigation. RN-A stated she called the DON right away for instruction on how to proceed. The DON had	F 610		

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F 610	Continued From page 45 advised RN-A to write a report and see if there was nay further information R1 had on the allegations. The DON had not suspended LPN-A to her knowledge. The DON had called back to the facility after she had spoken with her, but she had not talked to RN-A. The DON spoke to LPN-A. RN-A had never been educated on filing a report to the SA, nor reporting a suspicion of a crime to the police. RN-A looks for direction from the DOn and does what she is told. Since RN-A was an occasional staff person, she had not worked for a while prior to 9/4/20. Upon arriving to work that day, she was handed the policy on reporting, advised to read through it and ask if she had questions. RN-A had made no attempt to physically examine R1 on 9/4/20 after allegations of sexual abuse had been made. Review of the 9/4/20, incident report written by RN-A identified R1 advised NA-A and NA-B, she did not want LPN-A in her room. Staff asked RN-A to speak with her. R1 advised RN-a LPN-A was inappropriately touching her one time but was unable to give a date. LPN-A had come into her room. R1 was unsure why LPN-A had entered her room. R1's nasal cannula had come off and was on the floor. LPN-A picked it and it was wet. R1 advised she felt it was wet from condensation (from humidified oxygen). LPN-A had picked up her bedspread and started moving his hand along her "butt". LPN-A had not advised R1 what he was doing. She requested he not enter her room. Interview and document review on 9/15/20 at 9:43 a.m., with the SW identified the DON never came to the facility on 9/4/20, after being made aware of the incident. On 9/8/20, the SW arrived for work and saw RN-A's written report. She immediately went to the administrator (A) and	F 610		

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F 610	Continued From page 46 advised her this was a reportable incident. In review of the staffing schedule leading up to 9/4/20, it was identified LPN-A's last scheduled shifts were 9/3/20 and 8/31/20. LPN-A. R1 would not have seen LPN-A arrive for that shift on 9/3/20, as she would have been in bed, and the incident was reported to occur the last weekend shift time-frame he worked before 9/4/20. The SW agreed the incident would have most have likely occurred on 8/31/20. The SW was in charge of the investigation, which was still ongoing. She had plans to submit the 5 day report to the SA that day. The SW concluded she couldn ' t prove the allegation likely occur. The SW could not corroborate there was actual urine on the floor. LPN-A advised her the location of the urine was indeed at the end of the bed by R1's feet and not directly below where her bottom was. R1 was "definitely upset about it". The facility wanted to ensure LPN-A had not worked with R1 again. R1 was visibly upset, not crying, but anxious SW reported when she recalled her interview with R1. The SW believed, "what went wrong was he should have told her what he was doing". In reviewing the location of the fluid found on the floor, the SW agreed, there was no way R1's urine could have deposited at the foot of her bed, rather than directly below her bottom located in the middle of the bed, approximately over 2 feet away. The SW identified the only staff that were allowed to make reports the to SA were herself, the DON and administrator. She also agreed R1 wearing a brief would have limited deposits of urine on the floor and would have saturated R1's bed first. She agreed R1 made no mention of her bedding being wet. R1 also claimed LPN-A had not touched her brief, but was touching her buttocks. The SW agreed, R1's accounts her buttocks was being stroked by LPN-A's fingers	F 610		

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would be inconsistent if her underwear were pulled away from her body to feel a brief. The SW also agreed R1 had been independent to toilet and there was no need to physically check her for incontinence. The SW agreed the DON should have immediately suspended LPN-A upon hearing the allegation and reported to the SA. Facility procedures indicated only the SW, admin or the DON could submit a report to the SA. No other staff were allowed to submit reports of suspicions of a crime.

Interview on 9/15/20 at 10:20 a.m. with nurse practitioner (NP)-A identified she was unaware of R1's allegation of sexual abuse. The SW had called her, only to ask for the medical director (MD) number last wed. She was on call on 9/4/20 covering nights and weekends. NP-A rounded at the facility on 9/8/20, and was not notified about the allegations at that time either. She would expect the facility follow all policies and procedures and notify a residents provider when any allegation of abuse or neglect is made. NP-A was made aware of the interviews and events surrounding the allegations. NP-A expected the facility keep the resident safe and suspend any staff until an investigation was completed. R1 had improved in the ability to care for herself and could walk independently, toilet independently, was fully cognitive, and was set to go home in the next few days.

Interview on 9/15/20 at 10:53 a.m., with the DON identified she had received a call on 9/4/20 at approximately 10:00 p.m., RN-A had called her and advised R1 wanted to file a complaint against LPN-A. The DON stated RN-A offered no other information and she had not asked. The DON advised RN-A to find out what prompted such a

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F 610	Continued From page 48 complaint and to call her back. After approximately 15 minutes, the DON called the facility. LPN-A answered the phone. The DON asked him if he "did anything inappropriate" as R1 wanted to file a complaint against him. LPN_A denied any wrongdoing, but did advise the DON of the incident in question and stated he had done nothing wrong and advised her. The reason she asked LPN-A if he had done done anything inappropriate as he had been accused by R3 of being "gruff" with her with allegations "He looked at my vagina". The DON had filed a report but felt after investigation it was unsubstantiated as LPN-A had been providing personal cares and would "have to look" at R3's private parts. The DON agreed she had knowingly disclosed the alleged victim (R!)'s identity to LPN-A. The DON was satisfied with LPN-A's answer of no wrongdoing and stated he was not allowed to provide cares to R1 unless he was accompanied by another staff. The DON agreed, advising LPN-A of the alleged victims identity and not immediately suspending LPN-A placed R1 and other residents at risk for further abuse or retaliation. The DON failed to begin an investigation immediately and had not returned to the facility until 9/8/20. At that time, she was alerted to RN-A's written report. LPN-A was suspended pending the facilities investigation. The DON agreed her resolution and actions to prevent abuse and failing to follow facility policy put all residents at risk. Interview on 9/15/20 at 12:27 p.m. with the MD identified he had not been made aware of the incident until approximately 9/8/20. He was told by the facility R1 reported LPN-A felt her bottom, maybe she had not liked that and was found very upset. MD had not known "much more". MD was	F 610		

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F 610	Continued From page 49 unaware LPN-A was notified of R1's identity by the DON, nor that LPN-A had not been suspended immediately, or that no investigation was immediately performed upon identifying the allegation. The MD agreed the facility failed to keep R1 and all other 44 residents safe from retaliation or potential further abuse. He also agreed LPN-A should have been suspended, policies implemented, and an investigation should have been immediately started. Interview on 9/15/20 at 2:45 p.m. with the SW identified she had not called local police for suspicion of a crime but would do so right away. The SW had reported the incident to the MN Board of Nursing. Review of the 9/4/20, Reporting Abuse to Facility Management policy identified it was the responsibility of employees, consultants, physicians, family members, visitors, etc, to promptly report any incident of suspected abuse. All allegations were to be reported and thoroughly investigated. All reports made were to be made without fear or retaliation from facility or its staff. Reports were to be given to the DON. In her absence, reports were to be made the the charge nurse. Staff members shall not knowingly fail to report an incident or offense, screen reports, or withhold information from reporting agencies. If incidents were discovered after hours (8:00 a.m. to 5:00 p.m.), the admin or DON must be called at home and informed of the incident. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Employees accused of abuse were to be suspended immediately pending the outcome of the investigation. For reports of physical or sexual abuse, a thorough examination was to be	F 610		

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F 610	Continued From page 50 performed by licensed nurses. An immediate investigation was to be made and a copy provided to the administrator. Review of the 9/4/20, Abuse Investigations policy identified all reports of abuse were to be promptly reported and thoroughly investigated by the facility immediately but no later than 2 hrs after the allegation. The Ombudsman was to be notified and offered to participate in the investigation. The Ombudsman was to be notified of results of the investigation. Employees were to be suspended immediately. The administrator was to provide a written report of the results to the SA, local police. medical director and others within 5 days of the incident. There was no mention suspicions of a crime were to be reported immediately to local police, the SA, and any other licensing boards immediately but not later than 2 hours. There was also no mention investigations were to begin immediately following an accusation of abuse.	F 610		
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		10/27/20

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F 686	Continued From page 51 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to appropriately assess, monitor, intervene, and notify the physician for 1 of 6 residents (R2) reviewed who had a pressure ulcer. R2 developed serious illness when a newly identified pressure ulcer deteriorated significantly without all appropriate intervention, resulting in an immediate jeopardy for R2. The IJ began on 8/23/20, when staff identified a new onset pressure ulcer and the facility failed to appropriately assess, monitor, and notify the physician for 1 of 1 resident (R2). R2 suffered harm, having new onset pressure ulcer leading to hospitalization, wound debridement, and admission to hospice services with terminal illness and expectation of death. The facility administrator was notified of the IJ on 9/16/20 at 3:50 p.m. The IJ was removed on 9/17/20 at 3:45 p.m. but non-compliance remained at the lower scope and severity of G-actual harm at an isolated scope that is not immediate jeopardy. Findings include: R2's 7/16/20, quarterly MDS identified R2 had intact cognition and required extensive assistance of 2 staff with bed mobility and transfers. R2 required the use of a total mechanical lift. R2 was identified at risk for pressure ulcers and had no pressure ulcers at the time of the assessment. R2 was incontinent of bowel and bladder and relied on staff to assist in toileting and wore incontinence briefs. R2's current face sheet identified diagnoses of	F 686	R2 is no longer a resident at the facility. After her hospitalization she discharged to another facility. All residents with pressure ulcers have had their skin care plans reviewed and updated. a risk management incident was completed for each along with new Braden, Pain assessment and a comprehensive skin assessment. The attending physician, family and dietician have been updated on the resident's current status. Regional nurse consultant in-serviced RN-B on 9-16-20 on wound status, notification risk management and comprehensive skin progress note completion. On 10-21-20 RN-B was in-serviced on Skin and Wound Training in the facility EMR system. All Licensed Staff were in-serviced between 9-16-20 and 10-22-20 on the Wound Program with the process for new or declining wounds. Residents with new pressure injuries will have a risk management incident completed, and new Braden, comprehensive skin assessment and pain assessment completed. The primary provider and Medical Director or on call provider will be notified immediately via telephone of any new onset skin injury. The DON and family will be contacted via telephone. Request for medical exam will be made at the time of the notification.	

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F 686	Continued From page 52 paralysis on her right side, high blood pressure, chronic kidney disease, muscle weakness, anemia (low iron), difficulty swallowing, stroke, moderate protein-calorie malnutrition and history of skin cancer (forehead). R2's current care plan identified she had a self-care deficit related to impaired balance, impaired mobility, stroke, right sided paralysis, pain, edema, and pressure ulcer to her sacrum (tailbone). R2 required extensive assistance of 1 to 2 staff to turn and reposition in bed every 2 hours and as needed. R2 had a pressure reducing mattress in her bed and cushion in her wheelchair. Staff were to inform family and the medical provider of any new area of skin breakdown. Staff were to monitor skin issues daily until healed. Staff were to observe, report, and document as needed any changes in skin status to include appearance, color, wound healing, signs and symptoms of infection, wound size and stage. Interview on 9/16/20 at 10:18 a.m. with family member (FM)-A identified the interim infection control preventionist/wound care registered nurse (RN)-B called her at the end of August 2020. FM-A stated RN-B reported to her R2 had a new onset pressure ulcer the size of nickel. FM-A was unaware if R2's physician had evaluated the wound, or what treatments staff were providing. FM-A stated R2 went to the local hospital on 9/8/20 where she was evaluated and sent for higher acuity care at the regional hospital. Once admitted to the ICU at the regional hospital, the surgeon evaluated the pressure ulcer and deemed it needed to be debrided (areas of dead and infected tissue are removed). Surgery occurred on 9/9/20. FM-A stated the debridement	F 686	The dietician will be notified via e-mail. A comprehensive skin progress note will be completed along with wound site and wound stage. Resident wounds will be measured weekly by the wound nurse. Daily documentation on the wound will be completed buy the staff nurse. Newly admitted residents with the potential for high risk for pressure injury will have their skin assessed upon admission. Wounds that heal will be followed daily for an additional 2 weeks post closure to ensure wound tissue stability. Nursing staff will be notified of residents with new or worsening wounds via 24-hour report and the nurse aide care sheet will be updated accordingly. Licensed Staff will receive a Wound Training on 10-27-20 by AMT Facility Wound Nurse Representative. Licensed nurses were in-serviced on the policy for changes in condition policy with the focus on immediately notifying the MD, pressure ulcer risk assessment policy and daily skin checks on those residents with new or current pressure injuries. A line listing of the process was placed at each nurses station for the Licensed staff to reference. Other nursing staff were in-serviced on 10-26-20. Audits on daily skin documentation, completion of comprehensive skin assessment, MD notification of acute changes in resident condition and family/responsible notification audits will be 2x week for 2 weeks, weekly x3 weeks then monthly x1 year. Audits will be taken	

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F 686	Continued From page 53 resulted in a "softball sized" area of tissue being removed from R2's sacral area. FM-A stated she "could see the tailbone" and said the surgeon reported R2's rectum was only half an inch away and no further debridement could occur. R2 was discharged from the hospital on 9/15/20, and was admitted to hospice services where she was expected to die as a result of her wound. FM-A stated the facility had made no prior indication to her about the severity of the wound, or that it needed to be evaluated at any time by a physician. FM-A stated R2 had a stroke in April 2020, and became paralyzed on her right side. R2 required a total lift for transfers and was not able to reposition herself on her own. Review of R2's 8/25/20, Weekly Wound Assessment identified R2's pressure ulcer was first identified on 8/23/20. The assessment indicated the wound was a facility acquired pressure ulcer Stage III (full thickness tissue loss with some fat visible). The wound was described as beefy red with serosanguinous (clear to bloody) drainage. There was no tunneling noted. R2 reported pain during the assessment as "hurts a little bit" and indicated R2 had prescribed Tylenol, gabapentin and Tramadol for pain. Wound treatment was identified as: clean as ordered, pat dry, mix collagen powder with a hydrogel to form a paste and apply to the wound. Staff were to cover the wound and change the dressing daily. The medical doctor (MD), family, and registered dietician were notified on 8/25/20. There was no mention of the need to change the care plan or increase turning and repositioning or reviewing potential additional interventions. Review of R2's 8/25/20, progress notes identified no phone call was made to R2's MD to request	F 686	to QAPI by Administrator monthly x3 months for oversight and to ensure compliance. Responsible Party: Director of Nursing or Designee	

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F 686	Continued From page 54 assessment or to identify any additional treatment. Review of an 8/25/20, faxed notification to physician from facility staff to MD-B identified, "Res (resident) has a new OA (open area) on her sacrum, measures 1.3 cm [centimeters] x 0.8 cm, appears to be a PI3 (pressure ulcer, Stage III)". The fax also included information on R2's forehead. MD-B replied, "please check with dermatologist". There was no mention staff had used appropriate medical abbreviations to identify what "OA" and "PI3" were on the fax. In addition, there was no request for medical examination regarding the pressure ulcer. Review of an 8/26/20, faxed notification to physician from facility staff, included notation R2 had a pressure injury on sacrum- collagen mixed with hydrogel with foam dressing. Staff requested, "Can we also have order for Alginaide [protein supplement used for healing] twice daily for healing?- recommended by dietary nurse." No other details were made or asked of the provider. Staff made no mention for the need for medical examination. R2's 8/23/20 through 9/8/20, progress notes made no mention staff had performed daily assessments as indicated per care plan to identify whether the wounds increased, changed, or worsened, or the need for medical evaluation and treatment. There was no mention the MD had been informed of the progression or worsening of R2's pressure ulcer after 8/25/20. R2's 9/1/20, wound assessment identified the pressure ulcer was still classified as a stage III pressure ulcer, which had increased in size to	F 686		

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F 686	Continued From page 55 206 cm x 1.5 cm x 0.3 cm. The pressure ulcer was described as beefy red with a black center. Per the accompanying pressure ulcer guide, a full thickness ulcer now covered with eschar (black dead tissue) in the wound, should have been identified as an unstageable ulcer. A decline was noted, pain remained the same, and orders were unchanged. There was no mention R2's MD was notified of the swift decline in the pressure ulcer, or the need to change the care plan or increase turning and repositioning or reviewing potential additional interventions. Although the assessment indicated R2's family was notified, it was unclear what the family member (FM)-A was notified of. Review of a 9/2/20, fax to the physician identified R2 had experienced weight loss. The fax indicated her current weight was 129.6 pounds (lbs), down from 140.4 lbs in 1 month, totaling a 7.4 % weight loss. Staff did not indicate this was severe. Staff noted R2 was on a protein supplement to"promote wound healing." There was no mention staff of the worsening of R2's pressure ulcer, or her new onset severe weight loss as an urgent concern requiring medical evaluation and examination. The physician response to the fax noted "continue as above." R2's 9/8/20, final wound assessment identified the wound continued to have a beefy red, black center, with serosanguinous drainage but now had a foul odor. There was a new "lump" near the ulcer measuring 3 cm x 2.2 cm. The pressure ulcer itself now measured 4.9 cm x 2.0 cm x 1.2 cm and was still classified as a Stage III ulcer rather than unstageable. The MD was notified on 9/8/20 along with family. Additional information only listed R2 had an air mattress on her bed.	F 686		

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F 686	Continued From page 56 Review of the 9/8/20, SBAR change of condition entry identified R2 had drastically declined. R2 was noted as lethargic and would open her eyes only when staff talk to her. R2 was not eating and it was getting harder to give her oral medication. R2 had 2 wounds, 1 is surgical. Wounds are not healing. R2 had a surgical wound on her left side of her head that was not healing and a coccyx wound not healing as well. R2's vital signs were blood pressure 60/40 millimeters of mercury (mm/hg) (normal 120/80) temperature of 97.3 degrees Fahrenheit (F), respiratory 20 (normal 16-20) and oxygen saturation (SPO2) was 91% on room air. No other assessment vitals were documented as assessed. Staff identified they now called the MD on call. The MD ordered R2 be sent to the hospital. Review of R2's vital signs identified since R2's pressure ulcer was identified on 8/23/20, R2 showed signs and symptoms of sepsis as follows: 1) R2's temperature (T) was documented at or below 96.8 degrees F during 6 days from 8/23/20 through 9/8/20. Those days identified were 8/26/20, 8/27/20, 8/29/20, 8/31/20, 9/4/20, and 9/7/20 with the lowest temperature recorded as 95.9 on 9/7/20. 2) R2's HR was recorded as over 90 bpm on 9/7/20 and 9/8/20 with the highest documented rate at 98 bpm. 3) R2's SpO2, steadily declined from the normal 95-98%, 16 times from 8/31/20 through 9/8/20 and ranged from 90 % to 94%. 4) R2's systolic blood pressure started to decline on 9/1/20, when it was documented her blood pressure was 91/58, down from 120's over 60's to 60/40 on the day she was sent to the ER. Interview on 9/16/20 at 10:36 a.m., with NP-C	F 686		

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F 686	Continued From page 57 identified she was R2's primary care provider. She was unaware of the need for an assessment on a new onset pressure ulcer. Staff never called to notify her of the need to come to the facility or identify appropriate treatment. NP-C's partner, MD-B was not made aware of the pressure ulcer due to the facility using non-approved medical abbreviation on their fax. No phone call was ever received by herself or her partner MD-B. NP-C agreed any new onset pressure ulcer needs to be called to the provider immediately, as well as any changes in size, color, depth etc. R2 should have been sent to clinic or NP-C or MD-B would have came to the facility to assess R2. There is a local wound care clinic in Redwood Falls. Staff could have requested and then made an appointment for R2 at the clinic. Had NP-C been called, she would have immediately come to the facility as she lives within 15 minutes of the facility. It was her expectation the facility follow policies and procedures as well as best practices to prevent and treat pressure ulcers. NP-C was unaware if the facility had a trained wound care nurse, or if RN-B had been appropriately trained to perform an assessment. Interview and document review on 9/16/20 at 11:24 a.m., with RN-B identified she was the interim infection control preventionist and wound nurse while the permanent staff was on a medical leave. RN-B had minimal training on wound care. She was given the book which mimicked the wound care assessment in the facility electronic medical record. She had no formal IC training and had learned that position on the job as an RN. The facility procedure was to perform assessments 1 x per week. The delay from 8/23/20 to 8/25/20 of any formal assessment was caused by floor staff not performing	F 686		

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assessments. They had to wait for the official weekly assessment. No documentation was documented during daily dressing changes to identify changes of condition of pressure ulcers. Staff did not call providers for new onset pressure ulcers, nor did they call for worsening of pressure ulcers. Faxes were sent vs. calling the provider. RN-B identified in the fax sent to the MD on 8/25/20, "OA" stood for "open area" and PI3 was "pressure ulcer, Stage 3". RN-B agreed OA and PI3 were not appropriate medical abbreviations but eluded it was short-hand. The only time providers were called was if a situation was an emergency per RN-B. RN-B reviewed the regional hospital photos of R2's wound from the ED visit and agreed she had failed to accurately assess R2's wound. RN-B was unaware of the signs and symptoms of sepsis. RN-B agreed, looking back at her vital signs, R2 was indeed septic while she remained at the facility prior to her transfer.

Review of R2's 9/8/20, local hospital medical record identified R2 was sent to the ED for emergent medical evaluation for declining condition. R2 arrived at 7:11 p.m. with decreased level of consciousness and hypotension. R2 had a gradual decline in her overall health over the last several days. She has 2 known wounds. A sacral ulcer and she is status post basal cell (cancer) excision of the left frontal scalp in mid August. Upon admission, R2's vital signs were 100 degrees T, HR 104, respiratory rate (RR) 24, 92% SpO2. R2 had a large deep foul-smelling wound in the coccyx area. The MD documented there appeared to be necrotic tissue and surrounding area (inability to flex the neck forward) of erythema. Blood cultures were taken. The MD determined "the combination of fever,

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F 686	Continued From page 59	F 686		

hypotension and known wounds led to a fairly expedited evaluation for sepsis. There is very foul-smelling sacral wound is the likely cause of our presumed sepsis." R2 was diagnosed with sepsis. Plans were made to transport R2 to the regional hospital for higher level of care (ICU). R2's lab values identified severe infection. Her white blood cell count was 24.7 (normal 3.5 to 10.5).

Review of R2's 9/8/20, regional hospital medical record identified she was admitted to the regional hospital on 9/8/20 when she was transported for higher acuity needs. R2 had diagnoses of sepsis with septic shock related to her pressure ulcer, infected pressure ulcer, atrial fibrillation (abnormal heart murmur), lactic acidosis related to sepsis, heart attack related to lack of decreased blood flow, acute renal failure possibly related to dehydration related to poor oral intake in addition to sepsis, septic encephalopathy (brain dysfunction related to sepsis), blood cooagulopathy (blood clotting) possibly related to sepsis, difficulty swallowing, moderate protein malnutrition and palliative care. The hospital MD identified R2 resided at the long-term care facility. Over the past couple of days she had become increasingly lethargic. She was found to have sepsis due to an infected pressure ulcer. She was transferred from the local hospital for additional care. Surgery was consulted for debridement (done 9/9) which found a necrotic full thickness ulcer, measuring 12 cm x 12 cm x 3.5 cm. A palliative care consultation was requested. R2 was transferred out of the Coronary Intensive Care Unit. (CICU). After a palliative care meeting, R2 was transferred to hospice care. On the day of discharge of 9/15/20, R2 appeared in poor state of health and

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terminally ill. She will be discharged on hospice.

Interview on 9/16/20 at 12:03 p.m., with MD-B identified R2 had been seeing dermatology for non-healing wound. She was diagnosed with skin cancer on her forehead. R2 had a surgical procedure to remove the cancer and the area was left open to heal. MD-B had not seen or been aware of R2's pressure ulcer. She was faxed on 8/25/20 and thought the facility was asking her for treatment orders for her forehead. MD-B referred them to dermatology. She was unsure what "OA" and "PI3" were as they were not standard medical abbreviations. She had called the facility related to R2's forehead wound. She was advised the facility had a wound team and treatment had been initiated. MD-B again deferred to dermatology. MD-B stated she was not made aware of R2's new onset pressure ulcer and no mention was ever made to her regarding its onset or worsening condition. Facility staff had never called and asked her to examine R2. MD-B was advised some time after R2 had been admitted to the regional hospital by the local hospital MD, R2 had become septic from a pressure ulcer. MD-B advised the hospital MD she was unaware and had never known about the "gravity of the situation". MD-B expected any change of condition was to be called, not faxed to a provider to ensure accurate information was able to be conveyed to make the best treatment plan and identify if a medical examination was required.

Interview and document review on 9/17/20 at 10:00 a.m. with NP-A identified she was now R2's provider while R2 currently resided at a neighboring nursing home on hospice. NP-A saw R2 yesterday on 9/16/20, and stated the pressure

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F 686	Continued From page 61 ulcer "was completely preventable" had staff appropriately and timely assessed, monitored, intervened and notified the physician via phone. That resulted in R2's decline. Had R2 had early intervention, NP-A believed she may not be terminally ill now on hospice. NP-A reviewed R2's care plan and identified other than a pressure mattress and cushion, there were no other additional interventions to prevent the pressure ulcer. R2 was to be turned and repositioned prior to discharge every 2 hours and as needed. NA-A identified that turning schedule was for a resident with normal tissue tolerance and not at risk for pressure ulcers. When R2's pressure ulcer was identified, the care plan and repositioning schedule should have been updated to ensure R2 was turned and repositioned, sacrum offloaded, and her care plan updated to reflect her higher need for care. Interview and document review on 9/17/20 at 1130 a.m.. with the DON identified she was unaware of R2's pressure ulcer prior to her discharge. The DON agreed, any new onset wound needed to be assessed immediately, physician called, and interventions reviewed and revised to increase levels of care to prevent further breakdown. The DON agreed staff should never fax a physician when a change of condition is identified. The DON agreed RN-B was not appropriately trained to perform pressure ulcer assessments. The DON agreed all wounds needed to be checked daily, and results of those assessments documented so staff would be able to identify worsening condition and alert the provider. The DON agreed the facility's lack of assessment, monitoring, intervention and notification led to R2's worsening pressure ulcer resulting in harm. The DON reviewed the	F 686		

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F 686	Continued From page 62 photographs from the regional hospital record and agreed the wound would have appeared in the same condition hours earlier when facility staff had assessed it prior to transfer. The DON had not monitored RN-B's training or performance in pressure ulcer assessment, nor had she ensured policies and procedures were followed. Review of the facility's 9/1/20, Pressure Ulcer Risk Assessment policy identified the purpose of the procedure was to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers. The policy indicated pressure ulcers were usually formed when a resident remained in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissues. If pressure ulcers were not treated when discovered, they have the potential to become larger, painful and infected. Pressure ulcers are a serious skin condition for the resident. Staff were to routinely assess and document the condition of the resident's skin per facility wound and skin care policy for any signs and symptoms of irritation or breakdown. Staff were to immediately report any signs of a developing pressure ulcer to the supervisor. Staff were to perform routine skin inspections with daily care. Nurses were to be notified to inspect the skin if skin changes are identified. Nurses were to conduct skin assessments at least weekly to identify changes. Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. Additionally, the guidance indicated the following	F 686		

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information was to be recorded in the resident's medical record utilizing facility forms:
1) The type of assessment conducted.
2) The date and time and type of skin care provided, if appropriate.
3) The name and title (or initials) of the individual who conducted the assessment.
4) Any change in the resident's condition. if identified tied.
5) The condition of the resident's skin like the size and location of any red or tender areas, if identified.
6) How the resident tolerated the procedure or his/her ability to participate in the procedure.
7) Any problems or complaints made by the resident related to the procedure or observations of anything unusual exhibited by the resident.
8) The signature and title (or initials) of the person recording the data.
9) Documentation in medical record addressing MD notification if new skin alteration noted with change of plan of care if indicated.
10) Documentation addressing family, guardian or resident notification if new skin alteration is noted with change of the care plan if indicated.
Staff were to report other information in accordance with facility policy and professional standards of practice, notification of attending MD of skin concern, and notification should occur to the family, guardian or resident. While performing an assessment, if a new skin alteration was noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin, then staff were to proceed to care planning and interventions individualized for the resident and their particular risk factors and document the procedure.

Attempts were made to contact the facility's

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F 686	Continued From page 64 medical director for comment without success. The immediate jeopardy was removed on 9/17/20, when it could be verified by observation, interview and document review, protocols for resident pressure ulcer assessment and documentation had been reviewed and updated. Assessments were completed for all residents with current pressure ulcers including measurement. Care plans were also reviewed and revised as appropriate. The facility also identified systems to improve assessment of newly admitted residents with risk for pressure ulcers. Finally, the facility modified protocols for family and physician notification, and provided education to staff.	F 686		

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 9/14/20 through 9/22/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5378022C and H5378023C with licensing orders issued at S900 and S1980. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to appropriately assess, monitor, intervene, and notify the physician for 1 of 6 residents (R2) reviewed who had a pressure ulcer. R2 developed serious illness when a newly identified pressure ulcer deteriorated significantly without all appropriate intervention, resulting in an	2 900	R2 is no longer a resident at the facility. After her hospitalization she discharged to another facility. All residents with pressure ulcers have had their skin care plans reviewed and updated. a risk management incident was	10/27/20

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2 900	Continued From page 2 immediate jeopardy for R2. Findings include: R2's 7/16/20, quarterly MDS identified R2 had intact cognition and required extensive assistance of 2 staff with bed mobility and transfers. R2 required the use of a total mechanical lift. R2 was identified at risk for pressure ulcers and had no pressure ulcers at the time of the assessment. R2 was incontinent of bowel and bladder and relied on staff to assist in toileting and wore incontinence briefs. R2's current face sheet identified diagnoses of paralysis on her right side, high blood pressure, chronic kidney disease, muscle weakness, anemia (low iron), difficulty swallowing, stroke, moderate protein-calorie malnutrition and history of skin cancer (forehead). R2's current care plan identified she had a self-care deficit related to impaired balance, impaired mobility, stroke, right sided paralysis, pain, edema, and pressure ulcer to her sacrum (tailbone). R2 required extensive assistance of 1 to 2 staff to turn and reposition in bed every 2 hours and as needed. R2 had a pressure reducing mattress in her bed and cushion in her wheelchair. Staff were to inform family and the medical provider of any new area of skin breakdown. Staff were to monitor skin issues daily until healed. Staff were to observe, report, and document as needed any changes in skin status to include appearance, color, wound healing, signs and symptoms of infection, wound size and stage. Interview on 9/16/20 at 10:18 a.m. with family member (FM)-A identified the interim infection	2 900	completed for each along with new Braden, Pain assessment and a comprehensive skin assessment. The attending physician, family and dietician have been updated on the resident's current status. Regional nurse consultant in-serviced RN-B on 9-16-20 on wound status, notification risk management and comprehensive skin progress note completion. On 10-21-20 RN-B was in-serviced on Skin and Wound Training in the facility EMR system. All Licensed Staff were in-serviced between 9-16-20 and 10-22-20 on the Wound Program with the process for new or declining wounds. Residents with new pressure injuries will have a risk management incident completed, and new Braden, comprehensive skin assessment and pain assessment completed. The primary provider and Medical Director or on call provider will be notified immediately via telephone of any new onset skin injury. The DON and family will be contacted via telephone. Request for medical exam will be made at the time of the notification. The dietician will be notified via e-mail. A comprehensive skin progress note will be completed along with wound site and wound stage. Resident wounds will be measured weekly by the wound nurse. Daily documentation on the wound will be completed buy the staff nurse. Newly admitted residents with the potential for high risk for pressure injury will have their skin assessed upon admission. Wounds that heal will be followed daily for an	

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2 900	Continued From page 3 control preventionist/wound care registered nurse (RN)-B called her at the end of August 2020. FM-A stated RN-B reported to her R2 had a new onset pressure ulcer the size of nickel. FM-A was unaware if R2's physician had evaluated the wound, or what treatments staff were providing. FM-A stated R2 went to the local hospital on 9/8/20 where she was evaluated and sent for higher acuity care at the regional hospital. Once admitted to the ICU at the regional hospital, the surgeon evaluated the pressure ulcer and deemed it needed to be debrided (areas of dead and infected tissue are removed). Surgery occurred on 9/9/20. FM-A stated the debridement resulted in a "softball sized" area of tissue being removed from R2's sacral area. FM-A stated she "could see the tailbone" and said the surgeon reported R2's rectum was only half an inch away and no further debridement could occur. R2 was discharged from the hospital on 9/15/20, and was admitted to hospice services where she was expected to die as a result of her wound. FM-A stated the facility had made no prior indication to her about the severity of the wound, or that it needed to be evaluated at any time by a physician. FM-A stated R2 had a stroke in April 2020, and became paralyzed on her right side. R2 required a total lift for transfers and was not able to reposition herself on her own. Review of R2's 8/25/20, Weekly Wound Assessment identified R2's pressure ulcer was first identified on 8/23/20. The assessment indicated the wound was a facility acquired pressure ulcer Stage III (full thickness tissue loss with some fat visible). The wound was described as beefy red with serosanguinous (clear to bloody) drainage. There was no tunneling noted. R2 reported pain during the assessment as "hurts a little bit" and indicated R2 had prescribed	2 900	additional 2 weeks post closure to ensure wound tissue stability. Nursing staff will be notified of residents with new or worsening wounds via 24-hour report and the nurse aide care sheet will be updated accordingly. Licensed Staff will receive a Wound Training on 10-27-20 by AMT Facility Wound Nurse Representative. All Licensed nurses were in-serviced on the policy for changes in condition policy with the focus on immediately notifying the MD, pressure ulcer risk assessment policy and daily skin checks on those residents with new or current pressure injuries. A line listing of the process was placed at each nurses station for the Licensed staff to reference. Other Nursing staff were in-serviced on 10-26-20. Audits on daily skin documentation, completion of comprehensive skin assessment, MD notification of acute changes in resident condition and family/responsible notification audits will be 2x week for 2 weeks, weekly x3 weeks then monthly x1 year. Audits will be taken to QAPI by Administrator monthly x3 months for oversight and to ensure compliance. Responsible Party: Director of Nursing or Designee	

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2 900	Continued From page 4 Tylenol, gabapentin and Tramadol for pain. Wound treatment was identified as: clean as ordered, pat dry, mix collagen powder with a hydrogel to form a paste and apply to the wound. Staff were to cover the wound and change the dressing daily. The medical doctor (MD), family, and registered dietician were notified on 8/25/20. There was no mention of the need to change the care plan or increase turning and repositioning or reviewing potential additional interventions. Review of R2's 8/25/20, progress notes identified no phone call was made to R2's MD to request assessment or to identify any additional treatment. Review of an 8/25/20, faxed notification to physician from facility staff to MD-B identified, "Res (resident) has a new OA (open area) on her sacrum, measures 1.3 cm [centimeters] x 0.8 cm, appears to be a PI3 (pressure ulcer, Stage III)". The fax also included information on R2's forehead. MD-B replied, "please check with dermatologist". There was no mention staff had used appropriate medical abbreviations to identify what "OA" and "PI3" were on the fax. In addition, there was no request for medical examination regarding the pressure ulcer. Review of an 8/26/20, faxed notification to physician from facility staff, included notation R2 had a pressure injury on sacrum- collagen mixed with hydrogel with foam dressing. Staff requested, "Can we also have order for Alginaide [protein supplement used for healing] twice daily for healing?- recommended by dietary nurse." No other details were made or asked of the provider. Staff made no mention for the need for medical examination.	2 900		

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2 900	Continued From page 5 R2's 8/23/20 through 9/8/20, progress notes made no mention staff had performed daily assessments as indicated per care plan to identify whether the wounds increased, changed, or worsened, or the need for medical evaluation and treatment. There was no mention the MD had been informed of the progression or worsening of R2's pressure ulcer after 8/25/20. R2's 9/1/20, wound assessment identified the pressure ulcer was still classified as a stage III pressure ulcer, which had increased in size to 206 cm x 1.5 cm x 0.3 cm. The pressure ulcer was described as beefy red with a black center. Per the accompanying pressure ulcer guide, a full thickness ulcer now covered with eschar (black dead tissue) in the wound, should have been identified as an unstageable ulcer. A decline was noted, pain remained the same, and orders were unchanged. There was no mention R2's MD was notified of the swift decline in the pressure ulcer, or the need to change the care plan or increase turning and repositioning or reviewing potential additional interventions. Although the assessment indicated R2's family was notified, it was unclear what the family member (FM)-A was notified of. Review of a 9/2/20, fax to the physician identified R2 had experienced weight loss. The fax indicated her current weight was 129.6 pounds (lbs), down from 140.4 lbs in 1 month, totaling a 7.4 % weight loss. Staff did not indicate this was severe. Staff noted R2 was on a protein supplement to"promote wound healing." There was no mention staff of the worsening of R2's pressure ulcer, or her new onset severe weight loss as an urgent concern requiring medical evaluation and examination. The physician response to the fax noted "continue as above."	2 900		

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2 900	Continued From page 6	2 900		

R2's 9/8/20, final wound assessment identified the wound continued to have a beefy red, black center, with serosanguinous drainage but now had a foul odor. There was a new "lump" near the ulcer measuring 3 cm x 2.2 cm. The pressure ulcer itself now measured 4.9 cm x 2.0 cm x 1.2 cm and was still classified as a Stage III ulcer rather than unstageable. The MD was notified on 9/8/20 along with family. Additional information only listed R2 had an air mattress on her bed.

Review of the 9/8/20, SBAR change of condition entry identified R2 had drastically declined. R2 was noted as lethargic and would open her eyes only when staff talk to her. R2 was not eating and it was getting harder to give her oral medication. R2 had 2 wounds, 1 is surgical. Wounds are not healing. R2 had a surgical wound on her left side of her head that was not healing and a coccyx wound not healing as well. R2's vital signs were blood pressure 60/40 millimeters of mercury (mm/hg) (normal 120/80) temperature of 97.3 degrees Fahrenheit (F), respiratory 20 (normal 16-20) and oxygen saturation (SPO2) was 91% on room air. No other assessment vitals were documented as assessed. Staff identified they now called the MD on call. The MD ordered R2 be sent to the hospital.

Review of R2's vital signs identified since R2's pressure ulcer was identified on 8/23/20, R2 showed signs and symptoms of sepsis as follows:
1) R2's temperature (T) was documented at or below 96.8 degrees F during 6 days from 8/23/20 through 9/8/20. Those days identified were 8/26/20, 8/27/20, 8/29/20, 8/31/20, 9/4/20, and 9/7/20 with the lowest temperature recorded as 95.9 on 9/7/20.
2) R2's HR was recorded as over 90 bpm on 9/7/20 and 9/8/20 with the highest documented

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2 900	Continued From page 7	2 900		

rate at 98 bpm.
3) R2's SpO2, steadily declined from the normal 95-98%, 16 times from 8/31/20 through 9/8/20 and ranged from 90 % to 94%.
4) R2's systolic blood pressure started to decline on 9/1/20, when it was documented her blood pressure was 91/58, down from 120's over 60's to 60/40 on the day she was sent to the ER.

Interview on 9/16/20 at 10:36 a.m., with NP-C identified she was R2's primary care provider. She was unaware of the need for an assessment on a new onset pressure ulcer. Staff never called to notify her of the need to come to the facility or identify appropriate treatment. NP-C's partner, MD-B was not made aware of the pressure ulcer due to the facility using non-approved medical abbreviation on their fax. No phone call was ever received by herself or her partner MD-B. NP-C agreed any new onset pressure ulcer needs to be called to the provider immediately, as well as any changes in size, color, depth etc. R2 should have been sent to clinic or NP-C or MD-B would have came to the facility to assess R2. There is a local wound care clinic in Redwood Falls. Staff could have requested and then made an appointment for R2 at the clinic. Had NP-C been called, she would have immediately come to the facility as she lives within 15 minutes of the facility. It was her expectation the facility follow policies and procedures as well as best practices to prevent and treat pressure ulcers. NP-C was unaware if the facility had a trained wound care nurse, or if RN-B had been appropriately trained to perform an assessment.

Interview and document review on 9/16/20 at 11:24 a.m., with RN-B identified she was the interim infection control preventionist and wound nurse while the permanent staff was on a medical

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2 900	Continued From page 8 leave. RN-B had minimal training on wound care. She was given the book which mimicked the wound care assessment in the facility electronic medical record. She had no formal IC training and had learned that position on the job as an RN. The facility procedure was to perform assessments 1 x per week. The delay from 8/23/20 to 8/25/20 of any formal assessment was caused by floor staff not performing assessments. They had to wait for the official weekly assessment. No documentation was documented during daily dressing changes to identify changes of condition of pressure ulcers. Staff did not call providers for new onset pressure ulcers, nor did they call for worsening of pressure ulcers. Faxes were sent vs. calling the provider. RN-B identified in the fax sent to the MD on 8/25/20, "OA" stood for "open area" and PI3 was "pressure ulcer, Stage 3". RN-B agreed OA and PI3 were not appropriate medical abbreviations but eluded it was short-hand. The only time providers were called was if a situation was an emergency per RN-B. RN-B reviewed the regional hospital photos of R2's wound from the ED visit and agreed she had failed to accurately assess R2's wound. RN-B was unaware of the signs and symptoms of sepsis. RN-B agreed, looking back at her vital signs, R2 was indeed septic while she remained at the facility prior to her transfer. Review of R2's 9/8/20, local hospital medical record identified R2 was sent to the ED for emergent medical evaluation for declining condition. R2 arrived at 7:11 p.m. with decreased level of consciousness and hypotension. R2 had a gradual decline in her overall health over the last several days. She has 2 known wounds. A sacral ulcer and she is status post basal cell (cancer) excision of the left frontal scalp in mid	2 900		

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2 900	Continued From page 9 August. Upon admission, R2's vital signs were 100 degrees T, HR 104, respiratory rate (RR) 24, 92% SpO2. R2 had a large deep foul-smelling wound in the coccyx area. The MD documented there appeared to be necrotic tissue and surrounding area (inability to flex the neck forward) of erythema. Blood cultures were taken. The MD determined "the combination of fever, hypotension and known wounds led to a fairly expedited evaluation for sepsis. There is very foul-smelling sacral wound is the likely cause of our presumed sepsis." R2 was diagnosed with sepsis. Plans were made to transport R2 to the regional hospital for higher level of care (ICU). R2's lab values identified severe infection. Her white blood cell count was 24.7 (normal 3.5 to 10.5). Review of R2's 9/8/20, regional hospital medical record identified she was admitted to the regional hospital on 9/8/20 when she was transported for higher acuity needs. R2 had diagnoses of sepsis with septic shock related to her pressure ulcer, infected pressure ulcer, atrial fibrillation (abnormal heart murmur), lactic acidosis related to sepsis, heart attack related to lack of decreased blood flow, acute renal failure possibly related to dehydration related to poor oral intake in addition to sepsis, septic encephalopathy (brain dysfunction related to sepsis), blood cooagulopathy (blood clotting) possibly related to sepsis, difficulty swallowing, moderate protein malnutrition and palliative care. The hospital MD identified R2 resided at the long-term care facility. Over the past couple of days she had become increasingly lethargic. She was found to have sepsis due to an infected pressure ulcer. She was transferred from the local hospital for additional care. Surgery was consulted for debridement (done 9/9) which found a necrotic	2 900		

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2 900	Continued From page 10 full thickness ulcer, measuring 12 cm x 12 cm x 3.5 cm. A palliative care consultation was requested. R2 was transferred out of the Coronary Intensive Care Unit. (CICU). After a palliative care meeting, R2 was transferred to hospice care. On the day of discharge of 9/15/20, R2 appeared in poor state of health and terminally ill. She will be discharged on hospice. Interview on 9/16/20 at 12:03 p.m., with MD-B identified R2 had been seeing dermatology for non-healing wound. She was diagnosed with skin cancer on her forehead. R2 had a surgical procedure to remove the cancer and the area was left open to heal. MD-B had not seen or been aware of R2's pressure ulcer. She was faxed on 8/25/20 and thought the facility was asking her for treatment orders for her forehead. MD-B referred them to dermatology. She was unsure what "OA" and "PI3" were as they were not standard medical abbreviations. She had called the facility related to R2's forehead wound. She was advised the facility had a wound team and treatment had been initiated. MD-B again deferred to dermatology. MD-B stated she was not made aware of R2's new onset pressure ulcer and no mention was ever made to her regarding its onset or worsening condition. Facility staff had never called and asked her to examine R2. MD-B was advised some time after R2 had been admitted to the regional hospital by the local hospital MD, R2 had become septic from a pressure ulcer. MD-B advised the hospital MD she was unaware and had never known about the "gravity of the situation". MD-B expected any change of condition was to be called, not faxed to a provider to ensure accurate information was able to be conveyed to make the best treatment plan and identify if a medical examination was required.	2 900		

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2 900	Continued From page 11 Interview and document review on 9/17/20 at 10:00 a.m. with NP-A identified she was now R2's provider while R2 currently resided at a neighboring nursing home on hospice. NP-A saw R2 yesterday on 9/16/20, and stated the pressure ulcer "was completely preventable" had staff appropriately and timely assessed, monitored, intervened and notified the physician via phone. That resulted in R2's decline. Had R2 had early intervention, NP-A believed she may not be terminally ill now on hospice. NP-A reviewed R2's care plan and identified other than a pressure mattress and cushion, there were no other additional interventions to prevent the pressure ulcer. R2 was to be turned and repositioned prior to discharge every 2 hours and as needed. NA-A identified that turning schedule was for a resident with normal tissue tolerance and not at risk for pressure ulcers. When R2's pressure ulcer was identified, the care plan and repositioning schedule should have been updated to ensure R2 was turned and repositioned, sacrum offloaded, and her care plan updated to reflect her higher need for care. Interview and document review on 9/17/20 at 1130 a.m.. with the DON identified she was unaware of R2's pressure ulcer prior to her discharge. The DON agreed, any new onset wound needed to be assessed immediately, physician called, and interventions reviewed and revised to increase levels of care to prevent further breakdown. The DON agreed staff should never fax a physician when a change of condition is identified. The DON agreed RN-B was not appropriately trained to perform pressure ulcer assessments. The DON agreed all wounds needed to be checked daily, and results of those assessments documented so staff would be able	2 900		

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2 900	Continued From page 12 to identify worsening condition and alert the provider. The DON agreed the facility's lack of assessment, monitoring, intervention and notification led to R2's worsening pressure ulcer resulting in harm. The DON reviewed the photographs from the regional hospital record and agreed the wound would have appeared in the same condition hours earlier when facility staff had assessed it prior to transfer. The DON had not monitored RN-B's training or performance in pressure ulcer assessment, nor had she ensured policies and procedures were followed. Review of the facility's 9/1/20, Pressure Ulcer Risk Assessment policy identified the purpose of the procedure was to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers. The policy indicated pressure ulcers were usually formed when a resident remained in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissues. If pressure ulcers were not treated when discovered, they have the potential to become larger, painful and infected. Pressure ulcers are a serious skin condition for the resident. Staff were to routinely assess and document the condition of the resident's skin per facility wound and skin care policy for any signs and symptoms of irritation or breakdown. Staff were to immediately report any signs of a developing pressure ulcer to the supervisor. Staff were to perform routine skin inspections with daily care. Nurses were to be notified to inspect the skin if skin changes are identified. Nurses were to conduct skin assessments at least weekly to identify changes. Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of	2 900		

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2 900	Continued From page 13 pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. Additionally, the guidance indicated the following information was to be recorded in the resident's medical record utilizing facility forms: 1) The type of assessment conducted. 2) The date and time and type of skin care provided, if appropriate. 3) The name and title (or initials) of the individual who conducted the assessment. 4) Any change in the resident's condition. if identified tied. 5) The condition of the resident's skin like the size and location of any red or tender areas, if identified. 6) How the resident tolerated the procedure or his/her ability to participate in the procedure. 7) Any problems or complaints made by the resident related to the procedure or observations of anything unusual exhibited by the resident. 8) The signature and title (or initials) of the person recording the data. 9) Documentation in medical record addressing MD notification if new skin alteration noted with change of plan of care if indicated. 10) Documentation addressing family, guardian or resident notification if new skin alteration is noted with change of the care plan if indicated. Staff were to report other information in accordance with facility policy and professional standards of practice, notification of attending MD of skin concern, and notification should occur to the family, guardian or resident. While performing an assessment, if a new skin alteration was noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin, then staff were to proceed to care planning and interventions individualized for the resident and their particular risk factors and document the	2 900		

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2 900	Continued From page 14 procedure. Attempts were made to contact the facility's medical director for comment without success. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
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	21980		10/27/20

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21980	Continued From page 15 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 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 observation, interview and document review, the facility failed to ensure an allegation of sexual assault was reported immediately but no later than 2 hours, for 1 of 1 resident (R1) to the State Agency and local police.	21980	R1 had a risk management incident created 9-8-20. The MD was notified on 9-9-20. the Police were called on 9-15-20. Her vulnerable adult care plan was reviewed and updated and her	

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21980	Continued From page 16 Findings include: Review of the 9/8/20 report filed to the State Agency identified the social worker (SW) filed a report identifying the director of nursing (DON) was notified on 9/4/20 of inappropriate touching by licensed practical nurse (LPN)-A to R1. R1 advised staff she had not wanted LPN-A in her room. R1 alleged LPN-A, at an unknown date, had come into R1's room during the overnight hours and picked up R1's nasal cannula off the floor. LPN-A advised R1 there was fluid directly under the nasal cannula. R1 advised LPN-A it was from the condensation from humidified oxygen (O2). LPN-A picked up R1's bedding as R1 was laying in bed, and "moved his hands along her bottom". LPN-A had not advised R1 he was going to check her for alleged incontinence. Action taken by facility was identified as the DON advised LPN-A not to go into R1's room unless there was another staff person present. LPN-A was suspended per report on 9/8/20 pending an investigation. There was no mention the facility had reported the allegation to local police. Review of the facility's investigation notes, which began on 9/8/20 per the social worker, identified R1 advised (RN-A) on 9/4/20 at 10:10 p.m. she does not want a male care giver. LPN-A (no date or time) stated he came to work on 9/4/20 at 8:00 p.m. Over a week ago (unsure of date and time), the nurse aide on duty that night of the incident, was on break. R1 had reportedly put her call light on. LPN-A stated he answered it. LPN-A asked R1 what she needed. R1 stated she wanted cold water. LPN-A went to retrieve the water and upon return, noted a puddle or urine on the floor. LPN-A gave R1 her water and was trying to figure out where it came from. He lifted R1's cover	21980	preferences were reviewed and included and updated. Social Services met with R1 on 9-8-20, 9-9-20 and 9-10-20. MD was contacted to review resident request for external foley catheter. R1 was discharged on 9-22-20. All residents vulnerable adult care plans and preferences were reviewed and updated as needed. The Administrator and DON were in-serviced on abuse reporting, how to make a report in the SA portal, keeping resident complaints anonymous and suspension of employee/s upon suspicion of an allegation. The Administrator, Director of Nursing, ADON and Social Service Director all have access to the reporting platform and will be responsible for reporting allegations of abuse 24/7. Investigations with allegations of abuse will begin immediately. An on-call schedule was implemented on 9-28-20 on who to report to with Any Allegation of abuse and posted at each nurses station by the phone. This schedule will be updated weekly. Full time facility staff were in-serviced on 9-15-20 and 9-16-20 on the facility policy for reporting abuse with the emphasis of reporting incidents immediately. An All Staff meeting will be held on 10-26-20 to review the facility abuse policy with emphasis on when Law Enforcement, MD, Primary Provider, Ombudsman and guardian will be notified.	

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21980	Continued From page 17 slightly to check her bed. LPN-A advised R1 he was trying to figure out where the urine came from. LPN-A patted the bed. R1 had a "funny look on her face". LPN-A immediately put the covers down and cleaned up the floor. The notes identified R1 frequently refused to be changed and voids in her bed. "there was no inappropriate contact". We (facility staff) will care plan "no male caregivers. If he (LPN-A) needs to give medication or attend to medical tx [treatment], male nurses will take another female staff with them into the room". LPN-A was notified of his suspension on 9/8/20. Further investigation notes identified LPN-A also remarked when he finished cleaning up R1's floor, he and LPN-A were both "joking" when he left the room. On 9/8/20 at 8:35 a.m., R1 was interviewed by the SW. Notes of that interview identified R1 was outside smoking the evening of 9/4/20 and saw LPN-A report to work. R1 advised NA-A and NA-B not to let him come into her room since she felt uncomfortable. R1 was unclear on when the incident of inappropriate contact had occurred, but it was before 9/4/20. LPN-A had entered her room during the night, picked up her nasal cannula and said it was wet. R1 advised LPN-A it was wet from condensation. LPN-A left to get new tubing. R1 stated she was lying on her side with her back facing the doorway. When LPN-A returned, he touched her bottom inside her brief. R1 declared she had not used her call light to summon LPN-A that night. R1 declared no other staff has ever checked her for incontinence in that manner. R1 reported to the SW she felt safe. All staff were good to her except LPN-A. Both NA-A and NA-B were interviewed on 9/8/20. NA-B stated on the night of 9/4/20, R1 was outside smoking, came inside and was visibly shaking. NA-B asked if she was ok to which R1	21980	New employees will receive abuse education during their orientation period and will continue annually. Audits on reporting abuse allegations timely, facility notification posting of on-call staff for reporting will begin 2x week for 2 weeks, weekly x3 weeks then monthly x1 year. Audits will be taken to QAPI by Administrator monthly x3 months for oversight and to ensure compliance. Responsible Party: Director of Nursing or Designee	

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21980	Continued From page 18 replied "Not really. Seeing [LPN-A] makes me nervous". Both NA's took R1 to her room. R1 reported she had woken up to LPN-A checking her brief by sticking his finger in the back of her brief without telling her. R1 denied she had been wet. After talking to RN-A, NA-A and NA-B were advised LPN-A was not allowed in R1's room. Other staff were interviewed, but had no knowledge of the incident. Other residents were interviewed for safety and had no issues or concerns with staff. The Ombudsman was notified on 9/8/20 and the medical director was identified as being notified on 9/9/20. It was indicated in the report, after review of interviews, the facility identified "it was our belief LPN-A was not abusive, nor had intent of abuse. We believed he failed at communication..". Corrective action identified were male staff were to be accompanied by a female staff per resident request. Before returning to work, LPN-A would be inserviced on the importance of explaining to residents what he is doing before hand. LPN-A was to have one-on-one supervision for 1 week. RN-A was to be inserviced on 9/14/20 on the importance of getting all the facts first hand and reporting timely. The facility was to monitor its corrective actions. There was no mention facility management had identified they failed to report the suspicion of a crime to the SA and law enforcement within 2 hours of the allegation. R1's 8/17/20, admission Minimum Data Set (MDS) assessment identified she was fully cognitive and required extensive assist of 1 staff for toileting. R1's 8/18/20, progress notes identified R1 was admitted to the facility to receive rehabilitative services related to back pain and weakness and had pans to return home. Her admitting	21980		

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21980	Continued From page 19 diagnoses were low back pain, muscle weakness, chronic obstructive pulmonary disease (COPD). Interview on 9/14/20, with LPN-A identified the above incident occurred about a week ago to his knowledge. LPN-A was charge nurse on the night of the incident. R1 had put her call light on at approximately 3:00 a.m.. R1 had lost her oxygen tubing and it was laying on the floor in a puddle at the end of her bed by R1's feet. LPN-A left the room to get R1 new O2 tubing. LPN-A then proceeded to hook up R1's new tubing. R1 was laying in bed on her side, facing the wall, away from her door. R1 had a fluffy blanket. LPN-A advised her he was cleaning up the liquid fond underneath her O2 tubing. R1's blanket kept falling into the liquid on the floor as he was trying to clean it up. R1 was "uncomfortable with me at that point". LPN-A proceeded to touch R1's incontinence pad. LPN-A acknowledged he had not advised R1 what he was going to check her brief. LPN-A asked R1 if she wanted another staff to help her clean up, but she refused. LPN-A then stated he made a "joke" to which R1 laughed and he left the room. R1 had never made concerns known about not receiving assistance from male staff members. LPN-A was unsure how R1 could have leaked urine by the foot of her bed, when the area directly below her bottom, in the middle of the bed, was dry. R1 had been known to refuse cares. In hindsight, he should have been "more clear" during cares. On 9/4/20, registered nurse (RN)-A had advised him he was not to go into R1's room at any time. RN-A advised LPN-A he had touched R1 inappropriately. RN-A was going to call the DON and alert her to R1's allegations. The DON called back and spoke with LPN-A. He was told to keep his distance from R1 and have another staff member give R1 her medications.	21980		

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He was suspended on 9/8/20 pending an investigation. He had worked 9/4/20, 9/5/20, and 9/6/20. LPN-A had come to the facility on 9/14/20 as he was turning in his resignation effective 9/19/20. He was to work his upcoming 3 scheduled shifts on 9/17/20 through 9/19/20. LPN-A was resigning over the allegations.

Review of LPN-A's August and September, 2020, staff schedules and time clock entries identified LPN-A was scheduled to work overnight shifts on 8/27/20, 8/31/20, 9/3/20, 9/4/20, 9/5/20, and 9/6/20.. LPN-A's timecard identified he worked on:
1) 8/27/20, beginning at 6:00 p.m. until 6:46 a.m.
2) 8/31/20, beginning at 9:58 p.m. until 6:51 a.m.
3) 9/3/20, beginning at 10:01 p.m. until 6:40 a.m.
4) 9/4/20, beginning at 8:03 p.m. until 6:46 a.m.
5) 9/5/20, beginning at 6:02 p.m. through 6:28 a.m.,
6) 9/6/20 beginning at 5:58 p.m. and finishing at 7:09 a.m.

Review of LPN-A's employee file identified a performance review dated 9/14/20, 3 resident complaints were identified on 5/5/20, 6/22/20, and 9/4/20. The review identified LPN-A was flexible, worked both units and preferred working his night shift. LPN-A was identified having conflicts with some residents. LPN-A was to watch his tone as he had made "hurtful" statements without realizing it. It was identified he needed to "explain what you are doing, before you do it." LPN-A had a background check performed 6/3/20, which identified LPN-A had no criminal history reported. LPN-A was hired 11/18/19. There was no previous background check identified in his file. LPN-A had concern and problem resolution coaching's in his file. With regard to R3's complaint of LPN-A looking at her vagina, it was

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identified by the facility LPN-A had told R3 "You old people, its all in your head and you imagine things." R3 reported to management he made her "skin crawl" and was rude when other staff weren't around. He told her in a "creepy voice... I'm back.." when he returned to work. No disciplinary actions were included in LPN-A's file.

Interview on 9/14/20 with nursing assistant (NA)-A identified she was made aware of the incident on 9/4/20 by R1. R1 had reported to NA-A and NA-B she had seen LPN-A report for his shift that day at approximately 8:00 p.m.. R1 was outside. Staff noted R1 was afraid to come in and was shaking. R1 stated "I don't want that [expletive] working with me. R1 elaborated LPN-A had made he feel uncomfortable the last time he worked. LPN-A came into her room during the incident (unknown date) and started "poking" at her bottom. R1 wears an incontinence brief. R1 stated LPN-A was touching her inappropriately and did not know what to say to LPN-A at that time. R1 advised she was shocked and scared. R1 had not told anyone about the incident before 9/4/20, and she was afraid. R1 began to cry and would not go into any further detail with NA-A or NA-B. Both NA-A and NA-B left R1's room and advised RN-A immediately. RN-A went into R1's room and spoke to her about the incident. RN-A exited the room and looked to be visibly upset by the allegations R1 had advised her of. RN-A was witnessed telling LPN-A he was not to go into R1's room. R1 had never had any concerns with male staff. There was another male staff on the floor and R1 had no concerns with that male staff member.

Interview on 9/14/20 at 4:41 p.m. with NA-B identified R1 was a smoker and was outside the evening of 9/4/20. LPN-A had come in early,

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around 8:00 p.m. that day for his shift. NA-A and NA-B had noticed R1 was outside and rang the doorbell to come back into the facility. R1 was shaking and visibly upset. "She was petrified". NA-A and NA-B proceeded to ask R1 what the matter was. She was reluctant to say. R1 proceeded to tell the staff LPN-A had come into her room the other might when he worked. R1 advised LPN-A was checking her to see if she was wet. He stuck his fingers in her brief and touched her inappropriately. R1 takes care of herself and requires no assistance to toilet or put herself to bed etc. She only needed help when she was first admitted. R1 was expected to discharge soon. NA- A and NA-B left to find RN-A and advise her of the need to speak with R1 as soon as possible. RN-A was giving meds, and as soon as she was done, she would speak with R1. RN-A finished her medication pass and went to speak with R1 in her room. When RN-A came out of R1's room, she went to LPN-A who was working on that wing and advised him he was not to go into R1's room. Today on 9/14/20, when LPN-A came to work, R1 saw him come in. She began shaking. R1 kept watching the door to see if LPN-A was coming onto shift.

Observation and interview on 9/14/20 at 5:00 p.m., with R1 identified LPN-A works overnight shifts. R1 goes to bed early. On the date of the incident which R1 recalled as the last time he worked but was unsure of that date. R 1 stated LPN-A usually works weekends. It would have been the previous weekend night shifts to 9/4/20. R1 is awake and routinely sees the night shift report to work. R1 pointed to her calendar and identified the incident likely occurred between the dates of 8/28/20 and 8/31/20 which was the last scheduled weekend she saw him. LPN-A came into R1's room. She was sound asleep but woke

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up startled when she realized R1 was in her room. R1 wore O2 at night. Occasionally this falls off. Her tubing was laying on the floor at the foot of her bed. LPN-A picked up the tubing, gave it to R1 and she advised him it was wet. LPN_A stated it was wet on the floor where her tubing had been. LPN-A then grabbed wet the tubing, left the room, and came back with new O2 tubing. LPN-A advised her the spot of liquid on the floor at her feet "looked like pee". R1 advised him that was condensation from her O2 tubing with humidified oxygen. R1 stated she had not felt wet in her brief. LPN-A showed her the rag after he wiped up the liquid on the floor and showed her it was dirty. R1 slept with the over-bed lights on at all times and would lay on hr left side with her back away from the door, facing the wall. All of a sudden, R1 felt her covers being lifted and LPN-A was poking his fingers on her [expletive]. R1 stated she was" terrified". LPN-A had not said anything. He would start feeling her bottom, then stop. She heard clicking noises but was unsure what they were coming from. She thought it sounded like a pen light nurses use, but never saw any flash or light of any kind. R1 denied LPN-A had penetrated her in any way. "His finger was on my butt going up and down." R1 stated she had never been touched like that before. LPN-A was not touching her brief. R1 toilets herself and had no reason for LPN-A to attempt to check her brief for wetness. R1 identified she was "so scared" and "hadn ' t had the nerve to talk". LPN-A finally said "Do you need to be changed?". R1 was able to say "No". LPN-A replied to her "Alright then" and left her room. R1 stated LPN-A was very intentionally touching her buttocks and was not in any way on her brief. No staff had ever touched her that way before. R1 has never had any concerns with any male staff at any health facility. R1 elaborated the wet spot

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21980	Continued From page 24	21980		

on the floor was by her feet, not on the floor directly below her bottom. R1 was scared that night and again today on 9/14/20, when she saw LPN-A arrive for work. R1 was afraid LPN-A was coming back to work. R1 stated when she saw LPN-A today arrive for work, she started shaking, and got a "creepy" feeling in her stomach with nausea. R1 does not feel safe around LPN-A. "I can talk! Others [residents] can't". R1 was going home soon and walked independently with cares. Observations during interview of R1 identified was visibly shaken was teary eyed and expressed anger throughout the interview.

Interview on 9/14/20 at 6:06 p.m. with RN-A identified she was made aware of the allegation of sexual abuse from R1 by LPN-A on 9/4/20. RN-A stated NA-A and NA-B came up to her and advised her they were walking R1 to her room. R1 was shaking. R1 found out LPN-A was on duty and the staff wanted to make sure it was ok, and requested RN-A speak to R1. RN-A advised NA-A and NA-B she would speak to R1 as soon as she passed her medications. NA-A and NA-B followed up again. RN-A was almost finished with medication pass, and would be there shortly. RN-A had never met R1 before as she is an occasional staff member. On that day of 9/4/20, she was working in the back half of the facility. R1 reported she "just didn't like way things went. He [LPN-A] gives me the creeps". She couldn't recall what day the incident occurred, but identified it was about 2:00 a.m.. or 3:00 a.m. R1 reported her O2 would come off and fall on floor occasionally during the night. LPN-A opened her door, came in, saw it, and picked it up. He said it was wet, then advised R1 the floor was wet. Without notice, LPN-A put his hand underneath her covers. That made R1 "creep out". LPN-A took his finger and was "touching inside her brief.

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21980	Continued From page 25 RN-A asked her what she would like her to do about him. R1 said he wiped a spot by the bathroom door towards edge of bed. R1 denied being wet. R1 denied penetration, and stated he just left. RN-A assured R1 her concerns would be forwarded. R1 also advised RN-A she had been molested as a child and it felt "just like that". RN-A had not included that in her written report as R1 seemed embarrassed about her past molestation. RN-A had not performed an assessment or started an investigation. RN-A stated she called the DON right away for instruction on how to proceed. The DON had advised RN-A to write a report and see if there was nay further information R1 had on the allegations. The DON had not suspended LPN-A to her knowledge. The DON had called back to the facility after she had spoken with her, but she had not talked to RN-A. The DON spoke to LPN-A. RN-A had never been educated on filing a report to the SA, nor reporting a suspicion of a crime to the police. RN-A looks for direction from the DON and does what she is told. Since RN-A was an occasional staff person and had not worked for a while prior to 9/4/20. Upon arriving to work that day, she was handed the policy on reporting, advised to read through it and ask if she had questions. RN-A had made no attempt to physically examine R1 on 9/4/20 after allegations of sexual abuse had been made. Review of the 9/4/20, incident report written by RN-A identified R1 advised NA-A and NA-B, she did not want LPN-A in her room. Staff asked RN-A to speak with her. R1 advised RN-a LPN-A was inappropriately touching her one time but was unable to give a date. LPN-A had come into her room. R1 was unsure why LPN-A had entered her room. R1's nasal cannula had come off and was on the floor. LPN-A picked it and it was wet.	21980		

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21980	Continued From page 26	21980		

R1 advised she felt it was wet from condensation (from humidified oxygen). LPN-A had picked up her bedspread and started moving his hand along her "butt". LPN-A had not advised R1 what he was doing. She requested he not enter her room.

Interview and document review on 9/15/20 at 9:43 a.m., with the SW identified the DON never came to the facility on 9/4/20, after being made aware of the incident. On 9/8/20, the SW arrived for work and saw RN-A's written report. She immediately went to the administrator (A) and advised her this was a reportable incident. In review of the staffing schedule leading up to 9/4/20, it was identified LPN-A's last scheduled shifts were 9/3/20 and 8/31/20. LPN-A. R1 would not have seen LPN-A arrive for that shift on 9/3/20, as she would have been in bed, and the incident was reported to occur the last weekend shift time-frame he worked before 9/4/20. The SW agreed the incident would have most have likely occurred on 8/31/20. The SW was in charge of the investigation, which was still ongoing. She had plans to submit the 5 day report to the SA that day. The SW concluded she couldn ' t prove the allegation likely occur. The SW could not corroborate there was actual urine on the floor. LPN-A advised her the location of the urine was indeed at the end of the bed by R1's feet and not directly below where her bottom was. R1 was "definitely upset about it". The facility wanted to ensure LPN-A had not worked with R1 again. R1 was visibly upset, not crying, but anxious SW reported when she recalled her interview with R1. The SW believed, "what went wrong was he should have told her what he was doing". In reviewing the location of the fluid found on the floor, the SW agreed, there was no way R1's urine could have deposited at the foot of her bed, rather than directly below her bottom located in

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21980	Continued From page 27 the middle of the bed, approximately over 2 feet away. The SW identified the only staff that were allowed to make reports the to SA were herself, the DON and administrator. She also agreed R1 wearing a brief would have limited deposits of urine on the floor and would have saturated R1's bed first. She agreed R1 made no mention of her bedding being wet. R1 also claimed LPN-A had not touched her brief, but was touching her buttocks. The SW agreed, R1's accounts her buttocks was being stroked by LPN-A's fingers would be inconsistent if her underwear were pulled away from her body to feel a brief. The SW also agreed R1 had been independent to toilet and there was no need to physically check her for incontinence. The SW agreed the DON should have immediately suspended LPN-A upon hearing the allegation and reported to the SA. Facility procedures indicated only the SW, admin or the DON could submit a report to the SA. No other staff were allowed to submit reports of suspicions of a crime. Interview on 9/15/20 at 10:20 a.m. with nurse practitioner (NP)-A identified she was unaware of R1's allegation of sexual abuse. The SW had called her, only to ask for the medical director (MD) number last wed. She was on call on 9/4/20 covering nights and weekends. NP-A rounded at the facility on 9/8/20, and was not notified about the allegations at that time either. She would expect the facility follow all policies and procedures and notify a residents provider when any allegation of abuse or neglect is made. NP-A was made aware of the interviews and events surrounding the allegations. NP-A expected the facility keep the resident safe and suspend any staff until an investigation was completed. R1 had improved in the ability to care for herself and could walk independently, toilet independently,	21980		

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21980	Continued From page 28 was fully cognitive, and was set to go home in the next few days. Interview on 9/15/20 at 10:53 a.m., with the DON identified she had received a call on 9/4/20 at approximately 10:00 p.m., RN-A had called her and advised R1 wanted to file a complaint against LPN-A. The DON stated RN-A offered no other information and she had not asked. The DON advised RN-A to find out what prompted such a complaint and to call her back. After approximately 15 minutes, the DON called the facility. LPN-A answered the phone. The DON asked him if he "did anything inappropriate" as R1 wanted to file a complaint against him. LPN_A denied any wrongdoing, but did advise the DON of the incident in question and stated he had done nothing wrong and advised her. The reason she asked LPN-A if he had done done anything inappropriate as he had been accused by R3 of being "gruff" with her with allegations "He looked at my vagina". The DON had filed a report but felt after investigation it was unsubstantiated as LPN-A had been providing personal cares and would "have to look" at R3's private parts. The DON agreed she had knowingly disclosed the alleged victim (R!)'s identity to LPN-A. The DON was satisfied with LPN-A's answer of no wrongdoing and stated he was not allowed to provide cares to R1 unless he was accompanied by another staff. The DON agreed, advising LPN-A of the alleged victims identity and not immediately suspending LPN-A placed R1 and other residents at risk for further abuse or retaliation. The DON failed to begin an investigation immediately and had not returned to the facility until 9/8/20. At that time, she was alerted to RN-A's written report. LPN-A was suspended pending the facilities investigation. The DON agreed her resolution and actions to	21980		

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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
21980	Continued From page 29 prevent abuse and failing to follow facility policy put all residents at risk. Interview on 9/15/20 at 12:27 p.m. with the MD identified he had not been made aware of the incident until approximately 9/8/20. He was told by the facility R1 reported LPN-A felt her bottom, maybe she had not liked that and was found very upset. MD had not known "much more". MD was unaware LPN-A was notified of R1's identity by the DON, nor that LPN-A had not been suspended immediately, or that no investigation was immediately performed upon identifying the allegation. The MD agreed the facility failed to keep R1 and all other 44 residents safe from retaliation or potential further abuse. He also agreed LPN-A should have been suspended, policies implemented, and an investigation should have been immediately started. Interview on 9/15/20 at 2:45 p.m. with the SW identified she had not called local police for suspicion of a crime but would do so right away. The SW had reported the incident to the MN Board of Nursing. Review of the 9/4/20, Reporting Abuse to Facility Management policy identified it was the responsibility of employees, consultants, physicians, family members, visitors, etc, to promptly report any incident of suspected abuse. All allegations were to be reported and thoroughly investigated. All reports made were to be made without fear or retaliation from facility or its staff. Reports were to be given to the DON. In her absence, reports were to be made the the charge nurse. Staff members shall not knowingly fail to report an incident or offense, screen reports, or withhold information from reporting agencies. If incidents were discovered after hours (8:00 a.m.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	C 09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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21980	Continued From page 30	21980		

to 5:00 p.m.), the admin or DON must be called at home and informed of the incident. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Employees accused of abuse were to be suspended immediately pending the outcome of the investigation. For reports of physical or sexual abuse, a thorough examination was to be performed by licensed nurses. An immediate investigation was to be made and a copy provided to the administrator.

Review of the 9/4/20, Abuse Investigations policy identified all reports of abuse were to be promptly reported and thoroughly investigated by the facility immediately but no later than 2 hrs after the allegation. The Ombudsman was to be notified and offered to participate in the investigation. The Ombudsman was to be notified of results of the investigation. Employees were to be suspended immediately. The administrator was to provide a written report of the results to the SA, local police. medical director and others within 5 days of the incident. There was no mention suspicions of a crime were to be reported immediately to local police, the SA, and any other licensing boards immediately but not later than 2 hours. There was also no mention investigations were to begin immediately following an accusation of abuse.

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

November 3, 2020

Shirley Brekken, Executive Director
Board of Nursing
Park Plaza Building
2829 University Avenue Southeast, Suite 500
Minneapolis, Minnesota 55414

Dear Ms. Brekken:

This is relative to a full survey conducted at Valley View Manor HCC, 200 East Ninth Avenue, Lamberton, MN, 56152 and completed on September 22, 2020.

At the time of this survey it was determined that the residents in this facility have received substandard quality of care.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The director of nursing at the time of the survey was Shawna Dorr-Jones .

If you have any questions on this matter, please do not hesitate to call me.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

November 3, 2020

Randy Snyder, Executive Director
Board of Nursing Home Administrators
Park Plaza Building
2829 University Avenue Southeast, Suite 440
Minneapolis, Minnesota 55414

Dear Mr. Snyder:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the Board of Nursing Home Administrators whenever we determine that substandard quality of care has been provided to residents. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life, § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection Control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of Valley View Manor HCC, 200 East Ninth Avenue, Lamberton, MN, 56152, which was completed on September 22, 2020, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

F600 -- S/S: K -- 483.12(a)(1) -- Free From Abuse And Neglect;
F686 -- S/S: J -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer

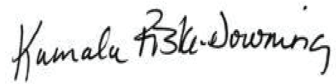
Freedom from Abuse, Neglect, and Exploitation (§ 483.12). Regulations in this area grant residents the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

Quality of Care (§ 483.25). Regulations in this area grant residents the right to receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The administrator is Ms. Dawn Giese.

If you have any questions, please feel free to contact me.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

October 13, 2020

Dr. Julie Kircher
Carris Health - Redwood Clinic
1100 E. Broadway
Redwood Falls, MN 56283

Dear Dr. Kircher:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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The above facility has prepared a plan to correct the deficiencies which we found during the survey. You can assist by discussing the survey findings with the facility's medical director. Copies of the survey findings which provide detailed information on the violations can be reviewed at the facility.

If you have any questions, please feel free to contact me.

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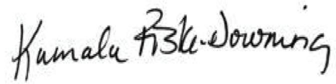

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
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St. Paul, MN 55164-0900
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Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

October 13, 2020

Dr. Annette Schmit-Cline
New Ulm Medical Center
1324 Fifth North Street
New Ulm, MN 56073

Dear Dr. Schmit-Cline:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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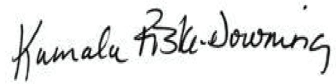

Kamala Fiske-Downing
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