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

Electronically delivered
October 21, 2020

Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

RE: CCN: 245410
Cycle Start Date: August 10, 2020

Dear Administrator:

On September 17, 2020, we notified you a remedy was imposed. On October 9, 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 9, 2020.

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

However, as we notified you in our letter of August 25, 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 August 10, 2020. This does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 Submitted
August 25, 2020

Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

RE: CCN: 245410
Cycle Start Date: August 10, 2020

Dear Administrator:

On August 10, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On August 4, 2020, the situation of immediate jeopardy to potential health and safety cited at F0600 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy 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 September 9, 2020.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 9, 2020 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 9, 2020, (42 CFR 488.417 (b)).

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Carris Health Care Center & Therapy Suites is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 10, 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 plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 10, 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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

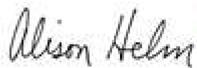
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 Submitted
September 17, 2020

Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

RE: CCN: 245410
Cycle Start Date: August 10, 2020

REVISED LETTER

Dear Administrator:

Please disregard the letter sent to your facility on August 25, 2020. That letter incorrectly imposed Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 9, 2020. The correct remedies are included below in this letter. At this time, there is no further action your facility needs to complete.

On August 10, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On August 4, 2020, the situation of immediate jeopardy to potential health and safety cited at F0600 was removed. It was determined that the facility had implemented actions to correct F0600. As a result, the immediate jeopardy was removed and cited as past non-compliance.

REMEDIES

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Carris Health Care Center & Therapy Suites is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 10, 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 plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by November 10, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions

as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Stewartville Care Center Section 488.417(b).

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 10, 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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

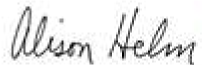
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245410 | A. BUILDING ______ B. WING ______ | C 08/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARRIS HEALTH CARE CENTER & THERAPY SUITES | 1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201 |

| (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<br><br>On 8/7/20 to 8/10/20, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct complaint investigation(s). Carris Healthcare Center & Therapy Suites was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The survey resulted in an immediate jeopardy (IJ) at F600 when multiple credible allegations of verbal abuse were not immediately reported to the required parties, investigated and protection provided to resident(s) at risk in the Sophia House unit to ensure they remained free of abuse. The administrator and registered nurse unit manager (RN)-B were notified of the IJ on 8/7/20, at 3:03 p.m. However, the facility had already implemented several action(s) including implementing their abuse policies and procedures, suspending the alleged perpetrator (AP) and completing education 'huddles' for re-educating staff to ensure timely reporting of witnessed abuse allegations. As a result of those actions, the findings of IJ are being issued as past non-compliance and were corrected as of 8/4/20.<br><br>In addition, an extended survey was conducted on 8/10/20.<br><br>The following complaint(s) were found to be substantiated: H5410019C, H5410020C, H5410021C, H5410022C - with a deficiency issued at F600. As a result of the investigation additional deficiencies were issued at F609 and F610. | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed

TITLE

(X6) DATE 09/03/2020

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 |
|---|---|---|---|
| | 245410 | A. BUILDING ______ B. WING ______ | C 08/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CARRIS HEALTH CARE CENTER & THERAPY SUITES** | **1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201** |

| (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<br>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.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 600 SS=K | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure multiple allegations of physical and verbal abuse were appropriately and promptly reported to the required person(s) and agencies, investigated and adequate protection | F 600 | Past noncompliance: no plan of correction required. | 9/3/20 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245410 | A. BUILDING ______ B. WING ______ | C 08/10/2020 |

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| CARRIS HEALTH CARE CENTER & THERAPY SUITES | 1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201 |

| (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 |
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| F 600 | Continued From page 2 | F 600 | | |

provided to ensure freedom from abuse for 3 of 4 residents (R2, R3, R4) whose allegations were reviewed. These findings constituted an immediate jeopardy (IJ) situation which had potential to affect 24 of 24 residents who resided on the Sophia House unit as the alleged perpetrator (AP) continued to work despite witnessed, credible allegations of abuse towards residents. However, the facility had taken appropriate action(s) to correct the identified non-compliance and, as a result, the findings are being issued as past non-compliance.

The IJ began on 7/23/20, when the AP (nursing assistant [NA]-A) was witnessed by multiple staff members to demean and verbally abuse R2 after she sustained a fall. This allegation was not immediately reported to the administrator or State agency (SA), nor was the allegation promptly investigated and protection provided to the resident(s) on the unit which lead to multiple other allegations being witnessed and also not acted upon, reported or investigated in a timely manner. The administrator and registered nurse unit manager (RN)-B were notified of the IJ on 8/7/20, at 3:03 p.m. However, the facility had already implemented several action(s) including implementing their abuse prevention policies and procedures, removing the AP from provision of resident care, and beginning shift-to-shift education 'huddles' to provide immediate re-education to staff to ensure all allegations are immediately reported to the proper personnel. As a result, the IJ was removed and the identified non-compliance was corrected as of 8/4/20.

Findings include:

A submitted SA incident report, dated 8/4/20,

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identified an allegation of "Emotional or Mental Abuse" was being submitted for R2. An incident date of 7/23/20 was listed, which identified R2 had fallen in the hallway due to her call light being on for an extended amount of time. A nursing assistant (NA)-A was then observed "yelling and shaming" R2 for falling in "an annoyed and harsh tone." R2 was listed in the report as, " ... confused and crying saying that she is sorry to [NA-A]."

R2's quarterly Minimum Data Set (MDS), dated 5/22/20, identified R2 had moderate cognitive impairment. On 8/7/20, at 9:50 a.m. R2 was interviewed and reported things were "fine" at the nursing home. R2 recalled falling in the hallway; however, could not recall any details of the fall or subsequent staff interactions when questioned saying, "I don't remember." R2 voiced no further concerns with staff care or treatment since she fell on 7/23/20.

A submitted SA incident report, dated 8/4/20, identified an allegation of "Emotional or Mental Abuse" was submitted for R3. An incident date of 8/4/20, was listed, which identified NA-A was heard " ... yelling 'What do you want, I can't understand you fiercely, while [another staff] can hear the resident crying."

R3's quarterly MDS, dated 7/28/20, identified R3 had severe cognitive impairment. On 8/7/20, at 10:01 a.m. R3 was interviewed using a staff member to interpret. R3 denied concerns with his care or treatment at the nursing home.

A submitted SA incident report, dated, 8/4/20, identified an allegation of "Emotional or Mental Abuse" was being submitted for R4. An incident

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date of 7/29/20, was listed, which identified R4 preferred baths over showers as she did not like to get her hair wet. However, NA-A told her she needed to take a shower. R4 was hard of hearing, so NA-A had "screamed at her and told her she needs [to] take the show [sic] whether she likes it or not." R4 then started crying according to the report.

R4's annual MDS, dated 5/15/20, identified R4 had moderate cognitive impairment. On 8/7/20, at 9:56 a.m. R4 was interviewed. R4 could not recall any incidents of having to take a shower and denied concerns with her care or treatment at the nursing home.

On 8/7/20, at 11:06 a.m. NA-B was interviewed and expressed she had heard of an incident which happened "one or two weeks ago" where a NA had been potentially verbally abusive to R2 after she fell. NA-B stated she thought the incident for R2 had been reported and voiced she had not heard of any other allegations regarding NA-A and other residents. NA-B stated she had worked with NA-A before and felt NA-A had a "poor attitude;" however, had never seen NA-A verbally or physically abuse a resident. NA-B stated her concerns with NA-A's attitude had been reported to a nurse before; however, the nurse was no longer employed at the nursing home and she was not sure if any follow-up had been done.

On 8/7/20, at 12:03 p.m. registered nurse (RN)-A was interviewed. RN-A recalled R2's fall on 7/23/20, and stated she had been called to R2's room due to a fall. When she arrived, there were several NA staff present, including NA-A and NA-C. RN-A stated she did recall NA-A making a

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comment to R2, while she laid on the floor, where she told her she needed to wait for assistance; however, RN-A stated she could not recall the exact quote of what had been said anymore. However, RN-A expressed she did recall "the tone" NA-A used when making the comment and described it as "a chastising manner." RN-A stated she felt the tone and overall comment was a dignified treatment concern as NA-A was someone who was "young and mouthy." RN-A stated she did not report the incident to anyone, including the unit manager or administrator, as it "didn't occur to me to go down that avenue." RN-A stated the facility' social worker (LSW)-A had just recently contacted her about the incident and expressed that was "the first I heard there was an incident around the whole thing [7/23/20 allegation]." Further, RN-A stated she had worked with NA-A again in the days and weeks since 7/23/20, and voiced NA-A had never been placed on any formal monitoring for her cares to her knowledge.

On 8/7/20, at 1:08 p.m. a telephone interview was completed with NA-C. NA-C voiced R2 had fallen on the evening of 7/23/20, and when she responded to the room to assist, she witnessed R2 laying on the floor covered in feces and appearing confused. NA-C stated NA-A was "standing over" R2 and "pretty much like shaming her and being rude to her" while scolding her for getting up unsupervised. NA-C stated R2 was crying and just kept voicing, "I'm sorry, I'm sorry" to NA-A as a result. NA-C reiterated NA-A was "just being so awful to [R2]" and it was upsetting adding she felt the interaction was abusive to R2 as NA-A was scolding R2 to "make [R2] feel ashamed." NA-C verified RN-B was present for this interaction, and NA-C expressed she thought

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| F 600 | Continued From page 6<br>RN-B was going to follow-up on reporting the concern to management so she did not report it herself. NA-C voiced additional concerns were seen or heard involving NA-A, including an incident "within the past week or so" where she heard R3 crying in his room and NA-A yelling at him, "[I] don't know what you want!" NA-C voiced she was unaware of any details involving R4's allegation of being forced to take a shower, however, expressed NA-A worked after the 7/23/20, incident, and continued the same use of generally mean behaviors with residents with no formal monitoring of her cares being done to her knowledge. NA-C stated she felt NA-A was overall "just rough with the patients" as she would often "rip off their clothes" and "things like that" when helping them. NA-C stated all of these concerns and allegations had been reported to the nurses and she "just figured every time I tell a nurse about it, they're supposed to report it." NA-C expressed she felt the staff needed to report these things and "more people need to come forward" when they see concerns. Further, NA-C voiced she had received some guidance and re-education on ensuring allegations are reported timely to the administrator or management team within the past few days.<br><br>A series of e-mails and statements from other direct care staff were provided which demonstrated the facility's completed investigation, as of 8/7/20, into the multiple allegations of verbal abuse by NA-A. These identified the following:<br><br>On 8/4/20, an e-mail from NA-C identified several concerns with staff and resident interactions pertaining to NA-A. The e-mail outlined NA-A had stated to her colleagues she was racist towards | F 600 | | |

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Somalians and verbalizing she wanted to " ... kill them all." The e-mail continued and NA-C outlined several allegations of verbal, and potential physical abuse, by NA-A which had been witnessed and/or heard. These included:

- "I have seen [NA-A] be rough in handling patients ... jerking residents and not gently taking off their clothing to the point of the residents being confused about her behavior and her ignoring them to get her 'job' done,"

- "I have heard outside of [R3's room], [NA-A] yelling "What do you want, I can't understand you" fiercely, while I can hear [R3] crying," and,

- "A few weeks ago [7/23/20] when [R2] had a fall in the hallway due to her light being on for an extended period of time, I came to help and saw [NA-A] yelling and shaming [R2] for falling and not waiting for her to answer her light. stating 'That's what you get, She needs to learn, Shouldn't have gotten up' she was scoffing and rolling her eyes at [R2] trying to ridicule her as she was laying on the floor covered in her own feces. [RN-B] told [NA-A] she fell because I asked you to get her light and you didn't.' ... [R2] is confused and crying saying that she is sorry to [NA-A]."

A statement was provided, dated 8/5/20, where homemaker (HMK)-A had described her interactions with NA-A. HMK-A outlined NA-A had "like an anger issue," which was a concern along with, " ... She yells at residents." The statement was signed by LSW-A.

A e-mail from RN-C, dated 8/4/20, identified a collection of statement pertaining to NA-A and her care of residents. A concern was listed which

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read, "The way [NA-A] talks with residents ... 'WHAT DO YOU WANT NOW!' ... 'YOU WERE JUST TO THE BATHROOM! YOU NEED TO WAIT!" ... 'URG, It's [blank line] call light again!" The concerns continued and included not answering call lights, using her telephone while at work and, " ... On Wednesday, July 28th, was [R4] bath night ... [R4] did not receive her, what was supposed to be bath, until around 8 pm. [NA-A] had told her she was only giving her a shower, and [R4] had no say in it. [R4] had started crying, because she wanted her bath and not a shower. [NA-A] continued on with the shower, despite listening to what [R4] wanted."

A provided untitled schedule, dated 6/30/20 to 8/7/20, identified NA-A's name at the top along with their worked and/or scheduled shifts. NA-A was identified as working on 7/23/20, 7/24/20, 7/25/20, 7/26/20, 7/28/20, 7/29/20 and 7/30/20 (before being removed from resident care on 8/4/20). Further, a provided Resident Bed List Report, dated 8/7/20, identified a total of 24 resident beds on the Sophia House Unit.

On 8/7/20, at 12:19 p.m. registered nurse unit manager (RN)-B, household coordinator (HC)-A and LSW-A were interviewed regarding R2, R3 and R4's allegation(s). RN-B stated a staff member had approached them on 7/31/20, and voiced NA-A was "really rude" and "not very nice to anybody" which caused them to start investigating so they could provide coaching or disciplinary action to NA-A. At that time, on 7/31/20, no allegations of abuse towards residents had been voiced to them. However, on 8/4/20, when they spoke to the initial NA who reported concerns on 7/31/20, they learned of multiple allegations of resident abuse. They

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| F 600 | Continued From page 9 immediately acted on them and reported them to the administrator and filed several vulnerable adult (VA) reports with the State agency. NA-A was then removed from resident care pending the investigations into the allegations, and the facility implemented shift to shift "staff huddles" to start re-educating direct care staff on abuse and the procedures for ensuring timely reporting. RN-B verified the allegations were not immediately reported when they happened which caused NA-A to continue working on the Sophia House unit from 7/23/20 to 8/4/20, on an unsupervised basis despite the multiple allegations of abuse which had been witnessed or heard by direct care staff. RN-B stated on 7/23/20, when the first allegation of resident abuse was witnessed, NA-A should have been "sent home immediately" to remove them from the situation and the investigation process started in accordance with their facility's abuse policies and procedures. This was important as the facility's "biggest priority" was to keep residents safe and "abuse should not be allowed to occur." At 12:39 p.m. the facility administrator joined the interview and verified she had not had any allegations of abuse reported to her until 8/4/20, despite the multiple allegations happening since 7/23/20 (12 days prior), which caused NA-A to continue working with residents unsupervised and without any monitoring from 7/23/20 to 8/4/20. The administrator stated when she learned of the allegations, they immediately reported them and started the shift to shift "huddles" to re-educate the staff. The administrator expressed they were still completing the investigation into the multiple allegations and were trying to figure out how direct care staff felt these were not reportable events when "it was clearly reportable." Further, the administrator voiced she had spoke to NA-A | F 600 | | |

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the day prior who "denied everything."

A provided Abuse Prohibition Policy, dated 6/2019, identified all residents will be free from abuse, neglect and mistreatment. The policy outlined abuse can include physical harm, pain, verbal abuse or involuntary seclusion. A section labeled, "Responsibilities," identified all staff, on an ongoing basis, would ensure residents are free from abuse and suspected cases of abuse would be, " ... thoroughly investigated and documented by the Administrator or designee." The policy directed suspected abuse must also be reported to the respective agencies, and, "Staff members, volunteers, family members, and others must report incidents of abuse or suspected abuse ..."

A provided Abuse and Neglect Reporting and Response Policy, dated 10/2019, identified a purpose of ensuring all staff follow the same procedures for reporting abuse and/or neglect. The policy outlined all employees of the nursing home were mandated reporters, and all allegations of abuse or neglect were to be promptly reported to the administrator who would then investigate the allegation(s). The policy continued, "If the accused is an employee of the facility, he/she will be placed on a paid administrative leave pending investigation ..."

The IJ, issued at past non-compliance began on 7/23/20, and was removed on 8/4/20, prior to the abbreviated survey as the facility had implemented sufficient step(s) to remove the immediacy and correct the identified non-compliance. These steps included implementing the facility's abuse prevention policies and procedures, removing the alleged

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| F 600 | Continued From page 11<br>perpetrator, NA-A, from resident care and implementing shift to shift huddles to begin re-educating the staff on abuse reporting procedures. | F 600 | | |
| F 609 SS=E | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the | F 609 | F609 Reporting of Alleged Violations | 9/25/20 |

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F 609

Continued From page 12

facility failed to ensure multiple allegations of potential physical and verbal abuse was reported to the administrator and State agency (SA) in a timely manner for 4 of 6 residents (R2, R3, R4, R1) whose allegations were reviewed.

Findings include:

A submitted SA incident report, dated 8/4/20, identified an allegation of "Emotional or Mental Abuse" was being submitted for R2. An incident date of 7/23/20 was listed, which identified R2 had fallen in the hallway due to her call light being on for an extended amount of time. A nursing assistant (NA)-A was then observed "yelling and shaming" R2 for falling in "an annoyed and harsh tone." R2 was listed in the report as, " ... confused and crying saying that she is sorry to [NA-A]."

A submitted SA incident report, dated 8/4/20, identified an allegation of "Emotional or Mental Abuse" was submitted for R3. An incident date of 8/4/20 was listed, which identified NA-A was heard " ... yelling 'What do you want, I can't understand you' fiercely, while [another staff] can hear the resident crying."

A submitted SA incident report, dated, 8/4/20, identified an allegation of "Emotional or Mental Abuse" was being submitted for R4. An incident date of 7/29/20 was listed, which identified R4 preferred baths over showers as she did not like to get her hair wet. However, NA-A told her she needed to take a shower. R4 was hard of hearing, so NA-A had "screamed at her and told her she needs [to] take the show [sic] whether she likes it or not." R4 then started crying according to the report.

F 609

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

NA-A was terminated on 08/07/2020

As noted in the 2567, huddles were started immediately at shift change to educate on Abuse Prevention Plan including, Abuse and Neglect Reporting and Response Policy, that states who is required to report abuse, what abuses should be reported, time frames of reporting, who to report the abuse allegations to. Daily huddles will now include the conversation of any vulnerable adult concerns. All staff have access to the Abuse Prevention Plan in its entirety on RiceNet.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

Cognitive Resident interviews will be conducted to determine if other residents on Sophia House were affected by the same deficient practice. Staff interviews will determine if other residents were affected.

3. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur.

Meetings were held on August 31, 2020 and September 2, 2020 for all RNs, LPNs, and TMAs that hold the position of

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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F 609

Continued From page 13

On 8/7/20, at 12:19 p.m. registered nurse unit manager (RN)-B, household coordinator (HC)-A and licensed social worker (LSW)-A were interviewed regarding R2, R3 and R4's allegation(s). RN-B stated a staff member had approached them on 7/31/20, and voiced NA-A was "really rude" and "not very nice to anybody" which caused them to start investigating. On 7/31/20, no allegations of abuse towards residents had been voiced to them. However, on 8/4/20, when they spoke to the initial staff member who reported concerns on 7/31/20, they learned of multiple allegations of resident abuse. They immediately acted on them and reported them to the administrator and filed several vulnerable adult (VA) reports with the State agency. RN-B verified the allegations for R2, R3 and R4 were not immediately reported to the adminstrator and State agency within two hours and should have been. At 12:39 p.m. the facility administrator joined the interview and verified she had not had any allegations of abuse reported to her until 8/4/20, despite the multiple allegations for R2, R3 and R4 happening since 7/23/20 (12 days prior). The administrator stated when she learned of the allegations, they immediately reported them and she expressed they were still completing the investigation into the multiple allegations and were trying to figure out how direct care staff felt these were not reportable events when "it was clearly reportable."

A submitted SA incident report, dated 6/11/20, identified an allegation of "Emotional or Mental Abuse" had been submitted for R1. An incident date was listed of 6/10/20 at 9:51 a.m. which outlined, "It was brought to writers attention on 6/9/2020 that some residents had reported

F 609

supervising staff. Agenda included:
a. Review of Abuse Prevention Plan
b. Reporting process of Abuse Prevention Plan
c. Step by step process of reporting on State Agency website
d. State Survey Results and Plan of Correction Strategies
e. Coaching and Corrective Actions; when is a coaching and corrective actions appropriate to issue. When should you send someone home pending investigation. When should you supervise and/or monitor performance to determine aggression, verbal communication, being rough with residents, poor attitude, lack of attentiveness with residents. When should you get Administration involved.
f. Implementing the discussion of Vulnerable Adult concern conversations at shift huddles.
g. A sticker was issued to all attendees with the phone numbers of Administrator and Director of Nurses and placed on their name badge to encourage staff to call if they have any questions or concerns regarding employee performance and Abuse Prevention Plan for reporting Abuse 24/7.

A process was put in place that when an employee is being monitored/supervised for #e (coaching and corrective actions), they will be required to have a one on one visit with Social Services to review Abuse Prevention Plan. Any concerns noted about the employee□s performance as it relates to vulnerable adult will be discussed.

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CARRIS HEALTH CARE CENTER & THERAPY SUITES | 1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201 |

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| F 609 | Continued From page 14<br>[NA-D] to be angry and rude at times ... Another staff person reported on 6/10/2020 that the staff brought it to her attention that [NA-D] was being rough during cares, rude and short-tempered."<br><br>A provided e-mail, dated 6/7/20, identified RN-D had sent a message to several other staff members, including the director of nursing (DON), on 6/7/20 (four days prior) which outlined concerns regarding NA-D had been brought to her attention. These concerns included, " ... residents are perceiving her as rude, wondering what they did to upset her, mean, yells at them, she is mad, and feel she is picking on them." The e-mail concluded, " ... will you please follow up?"<br><br>On 8/7/20, at 11:44 a.m. LSW-A and HC-B were interviewed regarding R1's allegation. LSW-A stated she received an e-mail on 6/9/20, regarding the e-mail sent on 6/7/20, and was told to "look into it." LSW-A and HC-B verified the allegation on 6/7/20, was not reported timely to the SA, and could not recall how or when the administrator was notified of the allegation. LSW-A stated she was not sure why the allegation had been reported late, and not within two hours as required, and added, "The staff need work on that."<br><br>A provided Abuse and Neglect Reporting and Response Policy, dated 10/2019, identified a purpose of ensuring all staff follow the same procedures for reporting abuse and/or neglect. The policy outlined all employees of the nursing home were mandated reporters, and all allegations of abuse or neglect were to be "immediately" reported to the administrator who would then report to the SA. However, the policy lacked any identified specified time frames for | F 609 | A process was put in place for a Question of the day on Vulnerable Adult Reporting to be placed on white marker board at the COVID19 screening table for all staff to answer. Results of answers will be recorded to determine if future educational opportunities exist.<br><br>An audit has been developed to ensure this plan of correction is compliant. The Administrator, Director of Nurses and Social Services will conduct the audits and report results to the Quality Assurance Performance Review Committee.<br><br>4. The date that each deficiency will be corrected.<br>September 18, 2020<br>5. Facility representative to ensure compliance.<br>Pamela Adam, Administrator | |

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| F 609 | Continued From page 15 when these reports should be made. | F 609 | | |
| F 610 SS=E | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure adequate protection(s) were provided to prevent ongoing abuse and reduce the risk of harm or injury while multiple allegations of abuse were investigated for 3 of 4 residents (R2, R3, R4) whose allegations were reviewed. This had potential to affect 24 of 24 residents residing on the Sophia House unit.<br><br>Findings include:<br><br>A submitted SA incident report, dated 8/4/20, identified an allegation of "Emotional or Mental Abuse" was being submitted for R2. An incident | F 610 | F610 Reporting of Alleged Violations<br><br>1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br><br>NA-A was terminated on 08/07/2020<br><br>As noted in the 2567, huddles were started immediately at shift change to educate on Abuse Prevention Plan including, Abuse and Neglect Reporting and Response Policy, that states who is | 9/18/20 |

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| F 610 | Continued From page 16<br>date of 7/23/20 was listed, which identified R2 had fallen in the hallway due to her call light being on for an extended amount of time. A nursing assistant (NA)-A was then observed "yelling and shaming" R2 for falling in "an annoyed and harsh tone." R2 was listed in the report as, " ... confused and crying saying that she is sorry to [NA-A]."<br><br>On 8/7/20, at 12:03 p.m. registered nurse (RN)-A was interviewed. RN-A recalled R2's fall on 7/23/20, and stated when she arrived at R2's room there were several NA staff present, including NA-A and NA-C. RN-A stated she did recall NA-A making a comment to R2, while she laid on the floor, where she told her she needed to wait for assistance; however, RN-B stated she could not recall the exact quote of what had been said anymore. However, RN-A expressed she did recall "the tone" NA-A used when making the comment and described it as "a chastising manner." RN-A stated she felt the tone and overall comment was a dignified treatment concern as NA-A was someone who was "young and mouthy." RN-A stated she did not report the incident to anyone, including the unit manager or administrator, as it "didn't occur to me to go down that avenue." RN-A stated she had worked with NA-A again in the days and weeks since 7/23/20, and voiced NA-A had never been placed on any formal monitoring for her cares to her knowledge.<br><br>On 8/7/20, at 1:08 p.m. a telephone interview was completed with NA-C. NA-C voiced R2 had fallen on the evening of 7/23/20, and when she responded to the room to assist, she witnessed R2 laying on the floor covered in feces and appearing confused. NA-C stated NA-A was "standing over" R2 and "pretty much like shaming | F 610 | required to report abuse, what abuses should be reported, time frames of reporting, who to report the abuse allegations to. Daily huddles will now include the conversation of any vulnerable adult concerns. All staff have access to the Abuse Prevention Plan in its entirety on RiceNet.<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>Cognitive Resident interviews will be conducted to determine if other residents on Sophia House were affected by the same deficient practice. Staff interviews will determine if other residents were affected.<br><br>3. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur.<br><br>Meetings were held on August 31, 2020 and September 2, 2020 for all RNs, LPNs, and TMAs that hold the position of supervising staff. Agenda included:<br>a. Review of Abuse Prevention Plan<br>b. Reporting process of Abuse Prevention Plan<br>c. Step by step process of reporting on State Agency website<br>d. State Survey Results and Plan of Correction Strategies<br>e. Coaching and Corrective Actions; when is a coaching and corrective actions appropriate to issue. When should you send someone home pending | |

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| F 610 | Continued From page 17<br>her and being rude to her" while scolding her for getting up unsupervised. NA-C stated R2 was crying and just kept voicing, "I'm sorry, I'm sorry" to NA-A as a result. NA-C reiterated NA-A was "just being so awful to [R2]" and it was upsetting adding she felt the interaction was abusive to R2 as NA-A was scolding R2 to "make [R2] feel ashamed." NA-C verified RN-B was present for this interaction, too, and she expressed she thought RN-B was going to follow-up on reporting the concern to management, so she didn't report it herself.<br><br>A submitted SA incident report, dated 8/4/20, identified an allegation of "Emotional or Mental Abuse" was submitted for R3. An incident date of 8/4/20 was listed, which identified NA-A was heard " ... yelling 'What do you want, I can't understand you' fiercely, while [another staff] can hear the resident crying."<br><br>A submitted SA incident report, dated, 8/4/20, identified an allegation of "Emotional or Mental Abuse" was being submitted for R4. An incident date of 7/29/20 was listed, which identified R4 preferred baths over showers as she did not like to get her hair wet. However, NA-A told her she needed to take a shower. R4 was hard of hearing, so NA-A had "screamed at her and told her she needs [to] take the show [sic] whether she likes it or not." R4 then started crying according to the report.<br><br>During interview on 8/7/20, at 1:08 p.m. a telephone interview was completed and NA-C voiced several concerns were seen or heard involving NA-A, including an incident "within the past week or so" where she heard R3 crying in his room and NA-A yelling at him, "[I] don't know | F 610 | investigation. When should you supervise and/or monitor performance to determine aggression, verbal communication, being rough with residents, poor attitude, lack of attentiveness with residents. When should you get Administration involved.<br>f. Implementing the discussion of Vulnerable Adult concern conversations at shift huddles.<br>g. A sticker was issued to all attendees with the phone numbers of Administrator and Director of Nurses and placed on their name badge to encourage staff to call if they have any questions or concerns regarding employee performance and Abuse Prevention Plan for reporting Abuse 24/7.<br><br>A process was put in place that when an employee is being monitored/supervised for #e (coaching and corrective actions), they will be required to have a one on one visit with Social Services to review Abuse Prevention Plan. Any concerns noted about the employee□s performance as it relates to vulnerable adult will be discussed.<br><br>A process was put in place for a Question of the day on Vulnerable Adult Reporting to be placed on white marker board at the COVID19 screening table for all staff to answer. Results of answers will be recorded to determine if future educational opportunities exist.<br><br>An audit has been developed to ensure this plan of correction is compliant. The Administrator, Director of Nurses and | |

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| F 610 | Continued From page 18<br>what you want!" NA-C voiced she was unaware of any details involving R4's allegation of being forced to take a shower, however, expressed NA-A worked after the 7/23/20 incident, and continued the same use of generally mean behaviors with residents with no formal monitoring of her cares being done to her knowledge.<br><br>On 8/7/20, at 12:19 p.m. registered nurse unit manager (RN)-B, household coordinator (HC)-A and LSW-A were interviewed regarding R2, R3 and R4's allegation(s). RN-B stated a staff member had approached them on 7/31/20, and voiced NA-A was "really rude" and "not very nice to anybody" which caused them to start investigating so they could provide coaching or disciplinary action to NA-A. At that time, on 7/31/20, no allegations of abuse towards residents had been voiced to them. However, on 8/4/20, when they spoke to the initial NA who reported concerns on 7/31/20, they learned of multiple allegations of resident abuse. They immediately acted on them and reported them to the administrator and filed several vulnerable adult (VA) reports with the State agency. NA-A was then removed from resident care pending the investigation(s) into the allegations; however, RN-B verified the allegations were not immediately reported when they happened which caused NA-A to continue working on the Sophia House unit from 7/23/20 to 8/4/20, on an unsupervised basis despite the multiple allegations of abuse which had been witnessed or heard by direct care staff. RN-B stated on 7/23/20, when the first allegation of resident abuse was witnessed, NA-A should have been "sent home immediately" to remove them from the situation and the investigation process started | F 610 | Social Services will conduct the audits and report results to the Quality Assurance Performance Review Committee.<br><br>4. The date that each deficiency will be corrected.<br>September 18, 2020<br>5. Facility representative to ensure compliance.<br>Pamela Adam, Administrator | |

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| F 610 | Continued From page 19 | F 610 | | |

in accordance with their facility' abuse policies and procedures. This was important as the facility's "biggest priority" was to keep residents safe and abuse "should not be allowed to occur." At 12:39 p.m. the facility administrator joined the interview and verified she had not had any allegations of abuse reported to her until 8/4/20, despite the multiple allegations happening since 7/23/20 (12 days prior), which caused NA-A to continue working with residents unsupervised and without any monitoring to ensure residents remained free of abuse from 7/23/20 to 8/4/20. Further, the administrator voiced she had spoke to NA-A the day prior who "denied everything."

A series of e-mails and statements from other direct care staff were provided which demonstrated the facility' completed investigation, as of 8/7/20, into the multiple allegations of verbal abuse by NA-A. These identified several concerns including an e-mail from RN-C, dated 8/4/20, identified a collection of statement pertaining to NA-A and her care of residents. A concern was listed which read, "The way [NA-A] talks with residents ... 'WHAT DO YOU WANT NOW!' ... 'YOU WERE JUST TO THE BATHROOM! YOU NEED TO WAIT!" ... 'URG, It's [blank line] call light again!" The concerns continued and included not answering call lights, using her telephone while at work and, " ... On Wednesday, July 28th, was [R4] bath night ... [R4] did not receive her, what was supposed to be bath, until around 8 pm. [NA-A] had told her she was only giving her a shower, and [R4] had no say in it. [R4] had started crying, because she wanted her bath and not a shower. [NA-A] continued on with the shower, despite listening to what [R4] wanted."

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| F 610 | Continued From page 20<br>A provided untitled schedule, dated 6/30/20 to 8/7/20, identified NA-A's name at the top along with their worked and/or scheduled shifts. NA-A was identified as working on 7/23/20, 7/24/20, 7/25/20, 7/26/20, 7/28/20, 7/29/20 and 7/30/20 (before being removed from resident care on 8/4/20). Further, a provided Resident Bed List Report, dated 8/7/20, identified a total of 24 resident beds on the Sophia House Unit.<br><br>A provided Abuse and Neglect Reporting and Response Policy, dated 10/2019, identified a purpose of ensuring all staff follow the same procedures for reporting abuse and/or neglect. The policy outlined all employees of the nursing home were mandated reporters, and all allegations of abuse or neglect were to be promptly reported to the administrator who would then investigate the allegation(s). The policy continued, "If the accused is an employee of the facility, he/she will be placed on a paid administrative leave pending investigation ..." | F 610 | | |

*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
August 25, 2020

Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

Re: Event ID: 3QMB11

Dear Administrator:

The above facility survey was completed on August 10, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On 8/7/20 to 8/1020, surveyors of this Department's staff visited the above provider for an abbreviated complaint survey to investigate complaint(s): H5410019C, H5410020C, H5410021C, H5410022C<br><br>No correction orders were issued. | 2 000 | | |

Minnesota Department of Health

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 09/03/20 |

Minnesota Department of Health

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| 2 000 | Continued From page 1<br><br>The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents. | 2 000 | | |