



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

Electronically Delivered  
July 15, 2022

Administrator  
Belgrade Nursing Home  
103 School Street  
Belgrade, MN 56312-0340

RE: CCN: 245418  
Cycle Start Date: May 25, 2022

Dear Administrator:

On July 8, 2022, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst  
Minnesota Department of Health  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File





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July 15, 2022

Administrator  
Belgrade Nursing Home  
103 School Street  
Belgrade, MN 56312-0340

Re: Reinspection Results  
Event ID: 734Z12

Dear Administrator:

On July 8, 2022 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 May 25, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst  
Minnesota Department of Health  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
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June 8, 2022

Administrator  
Belgrade Nursing Home  
103 School Street  
Belgrade, MN 56312-0340

RE: CCN: 245418  
Cycle Start Date: May 25, 2022

Dear Administrator:

On May 25, 2022, a survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

#### **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.

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.



The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

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

Susie Haben, Rapid Response  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Midtown Square  
3333 Division Street, Suite 212  
Saint Cloud, Minnesota 56301-4557  
Email: [susie.haben@state.mn.us](mailto:susie.haben@state.mn.us)  
Office: (320) 223-7356 Mobile: (651) 230-2334

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 August 25, 2022 (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 Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 25, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

#### **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/ltr\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/ltr_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](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.



Belgrade Nursing Home

June 8, 2022

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst

Minnesota Department of Health

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

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

PRINTED: 06/24/2022  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245418</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                           |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>05/25/2022</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET</b><br><b>BELGRADE, MN 56312</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| F 000                                                            | INITIAL COMMENTS<br><br>On 5/24/22 - 5/25/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be SUBSTANTIATED: H54181690C (MN00083544), with deficiencies cited at F600 and F604.<br><br>As a result of the investigation deficiencies were also cited at F607 and F609.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. |                                                                            |  | F 000                                                                                          |                                                                                                                          |                                                                    |                            |
| F 600<br>SS=E                                                    | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | F 600                                                                                          |                                                                                                                          |                                                                    | 7/1/22                     |

|                                                                       |       |            |
|-----------------------------------------------------------------------|-------|------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE  |
| Electronically Signed                                                 |       | 06/17/2022 |

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.



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

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET</b><br><b>BELGRADE, MN 56312</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                        |
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| F 600                                                            | <p>Continued From page 1</p> <p>§483.12(a) The facility must-</p> <p>§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 residents were free from verbal and physical abuse for 6 of 6 residents (R1, R2, R3, R4, R5, R6) who were involved in resident to resident verbal and/or physical altercations involving R1. Further, the facility failed to ensure allegations of resident to resident verbal and physical abuse were thoroughly investigated, assessed, and interventions care planned to ensure residents in the vicinity of R1 were safe after R1 demonstrated an escalation in verbal and physically aggressive behaviors directed at other residents in the facility.</p> <p>Findings include:</p> <p>R1's significant change Minimum Data Set (MDS) dated 3/31/22, identified R1 was severely cognitively impaired, sometimes understood others and sometimes others understood her. R1 required extensive physical assist with mobility and displayed one to three days of physical behaviors. Diagnosis included dementia, Alzheimers Disease (form of dementia), and Parkinson's Disease.</p> <p>R1's care plan, printed 5/24/22, identified the following information:<br/>-Revised 5/17/22, R1 has a history of delusional (fixed/false beliefs) thoughts related to dementia secondary to Parkinson's disease with "rapid</p> | F 600                                                                      | <p>A verbal review of the Abuse Policy was conducted at the Nurse and Aide meetings as well as re-education on reporting suspected abuse immediately to their supervisor and within 2 hours to the State Agency, focusing on Resident-to-Resident Abuse.</p> <p>Currently, no residents have a Vulnerability/Abuse Risk Assessment. Facility will develop and implement.</p> <p>Vulnerability/Abuse Risk Assessment to be done on current residents, new admissions, and at least yearly thereafter on all residents.</p> <p>Social Services or designee will monitor for compliance of Vulnerability/Abuse Risk Assessment being completed and report to QA committee quarterly.</p> |  |                                                                        |



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

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| F 600                                                            | <p>Continued From page 2</p> <p>changes in mood and behaviors without definitive cause." Interventions direct staff to not argue with R1; offer simple direct explanations; provide distraction and reorient as she allows; provide reassurance as needed; remove from areas and attempt to calm with one on one activities.</p> <p>-Revised 12/29/21, R1 has potential to be physically aggressive due to advanced cognitive loss with episodes of hitting, kicking, swinging out at staff and residents. Goal identified R1 would have fewer than three episodes of physical abuse per month. Interventions directed staff in communication techniques; when R1 becomes agitated, intervene before it escalated, guide her away from source of distress, if response is aggressive staff walk calmly away and approach later;</p> <p>-Initiated 4/13/21, R1 has dementia with impaired cognitive function, short/long term memory loss, and impaired thought process. Interventions direct staff to use R1's preferred nickname, identify themselves at each interaction, face R1 when speaking and make eye contact, reduce any distractions; engage R1 in simple structured activities that ovoid overly demanding tasks; break tasks into one step at a time.</p> <p>R1's care plan lacked a safety/abuse/vulnerability plan of care with associated goals and interventions to decrease R1's risk of abuse from others.</p> <p>Review of R1's record identified R1's verbal and physical aggressive behaviors directed towards residents increased around 3/30/22, in which R1 was documented to demonstrate multiple occurrences of verbal and physical aggression towards other residents; however, facility records lacked evidence of further identification and</p> | F 600                                                                      |                                                                                                                          |  |                                                                    |



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| F 600                                                            | <p>Continued From page 3</p> <p>assessment of the residents who were and might have been effected by R1's verbally and physically abusive behaviors. In addition, there was no evidence of ongoing protection plans for all residents potentially affected. Furthermore, R1's record did not include a completed comprehensive analysis/evaluation of verbal and/or physical behaviors and/or effectiveness of behavioral interventions to determine if R1 required new interventions as a result of the increased behaviors in order to mitigate further episodes of verbal and physical aggression. R1's record lacked evidence R1's primary physician was updated on R1's increased verbal and physical aggression prior to 5/13/22 or evidence the facility followed up on the lack of physician response prior to a return fax on 5/20/22.</p> <p>R1's progress note, dated 3/30/22, at 7:27 a.m. identified R1 was "mocking" her tablemates at supper the previous evening.</p> <p>R1's progress note, dated 4/14/22, at 10:01 p.m. identified R1 entered R4's room and after R4 raised his voice and told R1 to leave, "She started screaming at him and waving both arms, pointing and getting increasingly agitated. [R4] then yelled back and was going to shut his bedroom door when [R1] threw her partial glass of Ensure (nutritional supplement) at [R4] ..." After the incident, R1 "calmed" for short periods; however, displayed "quick, intense outbursts of anger, yelling, and being short with other residents ... After the incident, R1 threatened to "smack" R3, who was located in the lobby, if he stood up again.</p> <p>R4's annual MDS dated 3/4/22, identified R4 was diagnosed with dementia and was severely</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET</b><br><b>BELGRADE, MN 56312</b>                           |  |                                                                    |
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| F 600                                                            | <p>Continued From page 4</p> <p>cognitively impaired; however, he was able to understand others without issues and others understood him. R4's progress note, dated 4/14/22, at 10:07 p.m. identified the interaction with R1. R4's care plan, printed 5/25/22, lacked a safety/abuse/vulnerability plan of care with associated goals and interventions to decrease R4's risk of abuse from others.</p> <p>R3's quarterly MDS dated 3/23/22, identified R3 was diagnosed with dementia and was severely cognitively impaired; however, he was usually able to understand others and others understood him. R3's progress notes lacked documented evidence that on 4/14/22 he was threatened by R1. R3's care plan, printed 5/25/22, lacked a safety/abuse/vulnerability plan of care with associated goals and interventions to decrease R3's risk of abuse from others.</p> <p>R1's progress note, dated 4/15/22, at 1:33 p.m. identified R1 "was very anxious this shift" in which she "yelled" at other residents.</p> <p>A physician's communication form, dated 4/22/22, updated R1's neurologist R1 was "impulsive and becomes fixated on things at times ...delusional at times." Communication form lacked any update on R1's verbal/physical aggression towards other residents.</p> <p>A dictated Minneapolis Clinic of Neurology progress note, dated 4/22/22, identified R1 was seen, in person, by neurology. R1's history of present illness (HPI) indicated "for the past few months" she demonstrated delusions (fixed/false beliefs) and was more confused and disoriented about time and space. "So far she still can be directed. No agitation or aggressive behavior."</p> | F 600                                                                      |                                                                                                                          |  |                                                                    |



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| F 600                                                            | <p>Continued From page 5</p> <p>The physician suggested the facility continue "behavior justification and try redirecting. If not helping, will consider Seroquel (antipsychotic medication) 12.5 milligrams (mg) as needed."</p> <p>R1's Order Summary Report, dated 5/24/22, identified on 4/22/22 R1 was setup to monitor the following behaviors: "hitting, kicking, biting, screaming, delusions, hallucinations, yelling at other residents, going after other residents aggressively."</p> <p>R1's progress note, dated 4/23/22, at 7:32 p.m. identified R1 was "yelling" at other resident(s) and "appeared very agitated this shift."</p> <p>R1's progress note, dated 4/25/22, at 8:50 p.m. identified R1 was "hitting another resident [R5]."</p> <p>R5's significant change MDS dated 5/19/22, identified R5 was diagnosed with dementia and depression and was severely cognitively impaired. R5 was rarely or never understood and only sometimes understood others. R5's progress notes lacked documented evidence that on 4/25/22 she was hit by R1. R5's care plan, printed 5/25/22, lacked a safety/abuse/vulnerability plan of care with associated goals and interventions to decrease R5's risk of abuse from others.</p> <p>R1's progress note, dated 5/1/22, at 8:04 p.m. identified R1 was "attempting to scold other residents ..."</p> <p>R1's progress note, dated 5/6/22, at 8:31 p.m. identified R1 was "verbally aggressive with other residents."</p> <p>R1's progress note, dated 5/11/22, at 9:14 p.m.</p> | F 600                                                                      |                                                                                                                          |  |                                                                    |



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| F 600                                                            | <p>Continued From page 6</p> <p>identified R1 wheeled up to other residents and hugged them from behind and was "hollering" at them when she said something to them and they did not answer or she could not hear them. Further, [R1] wheeled up to R6 and "slapped" R6 five times with a rolled up newspaper.</p> <p>R6's quarterly MDS dated 2/24/22, identified R6 was diagnosed with Alzheimer's Disease and was severely cognitively impaired. R6 usually understood others and other usually understood her. R6's progress notes lacked documented evidence that on 5/11/22 she was slapped by R1. R6's care plan, printed 5/25/22, lacked a safety/abuse/vulnerability plan of care with associated goals and interventions to decrease R6's risk of abuse from others.</p> <p>R1's progress note, dated 5/13/22, at 9:36 p.m. identified LPN-B, after she responded to screaming and yelling from the lobby, witnessed NA attempting to stop R1 from hitting R2 with articles of baby clothing. R1 became combative with NA. R2 yelled "she was hitting me!" R2 was asked to go her room, which she did. R1 continued to try and make contact with R2 as she hit and kicked at NA. LPN-B "then got behind [R1] and put her arms beck [sic] her back and assisted her back into her wheelchair."</p> <p>A Physical Event Risk Management report, dated 5/13/22, identified R1 and R2's physical interaction. The report indicated R1 was oriented to person only. There were no predisposing environmental, physiological, or situation factors identified. Immediate action taken described R2 was assessed for injury, staff attempted to redirect R1, R1 continued to seek out R2, R1 was assisted with a bath to which after she was up</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| F 600                                                            | <p>Continued From page 7</p> <p>and down the hall "looking angry", and then NA assisted her to bed.</p> <p>A Facility Reported Incident (FRI) submitted to the Stage Agency (SA) on 5/13/22, at 9:16 p.m. identified the following occurred at 7:48 p.m.: "[R1] physically went after [R2]. [R2] began screaming and yelling for help. When the [nursing assistant - NA] arrived on scene she witnessed [R1] hitting [R2] with clothing. [NA] then tried to stop [R1], then [R1] physically went after [NA], hitting, kicking and screaming at [NA], [R1] still trying to get past [NA] to get to [R2]. Nurse arrived on scene shortly after [NA] and instructs [R2] to go to their room while attempting to redirect [R1] and return [R1] to their wheelchair, [R1] had to be physically restrained from hitting [NA] and [R2]. [R1] was then again attempted to be redirected, but she continued to be angry and look for people to go after. [R2] did leave the room when asked."</p> <p>R2's quarterly MDS dated 3/24/22, identified R2 was moderately cognitively impaired. R2 understood others and others understood her. R2's diagnosis included post-traumatic stress disorder, paranoid schizophrenia, anxiety, depression, manic depression (bipolar disease), and psychotic disorder. R2's progress notes lacked documented evidence that on 5/13/22 she was hit by R1. R2's care plan, printed 5/25/22, lacked a safety/abuse/vulnerability plan of care with associated goals and interventions to decrease R2's risk of abuse from others.</p> <p>A facility nursing home communication form, dated 5/14/22, identified the facility faxed R1's provider R1's 5/13/22 behavior progress note. The providers response, dated 5/20/22, provided</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| F 600                                                            | <p>Continued From page 8</p> <p>an order to start Seroquel 50 mg twice a day.</p> <p>R1's progress note, dated 5/15/22, at 9:58 p.m. identified R1 "has been up and down with behaviors" in which she swung out and slapped at other residents.</p> <p>A facility nursing home communication form, dated 5/17/22, identified the facility faxed R1's provider a 5/17/22 S.B.A.R (situation, background, assessment, recommendation) progress note related to incidents that occurred on 5/13/22 and 5/15/22. The form indicated R1's 5/10/22 - 5/16/22 progress notes were attached. The providers response, dated 5/20/22, provided an order to start Seroquel 50 mg twice a day.</p> <p>R1's progress note, dated 5/23/22, at 7:34 p.m. identified R1 was "yelling at other residents in the dining room."</p> <p>Event Risk Management reports were requested for R2, R3, R4, R5, and R6 which identified investigation and follow-up related to R1's resident-to-resident behavioral interactions with them. None were provided.</p> <p>During interview via telephone on 5/24/22, at 12:22 p.m. R1's representative (FM)-A stated she knew R1's behaviors were escalated and identified the facility contacted her after an episode where R1 "was not very nice to another resident" and R1 required an order for Seroquel. FM-A was contacted again shortly after when the facility called and updated her "[R1] had another bad episode" and needed an order for intramuscular (IM) Haldol (antipsychotic medication). FM-A confirmed R1 hollered out at times in the dining room, hit out at staff and</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| F 600                                                            | <p>Continued From page 9</p> <p>pinched her personally in the past; however, she denied knowledge R1 was combative to other residents. FM-A explained R1 had a longer standing history of behaviors prior to her facility admission and at that time family could not determine the behavior's etiology. FM-A denied the facility reached out to her to partake in a comprehensive behavior assessment/analysis process related to R1's escalated behaviors.</p> <p>When interviewed via telephone on 5/24/22, at 12:40 p.m. FM-B acknowledged she was not aware R2 was involved in a resident-to-resident altercation on 5/13/22. She explained she expected a phone call if such an event occurred: "I am surprised I never got one [phone call]."</p> <p>When interviewed on 5/24/22, at 12:53 p.m. registered nurse (RN)-A stated verbalized threat(s) directed at others, which was intended to hurt someone else, was a form of verbal abuse, along with throwing things at another resident. If abuse was witnessed she was expected to report the incident to the SA within two hours "if serious injury" occurred. RN-A explained R1's "dementia and disease process has gradually gotten further into it and we are seeing more behaviors with her." Examples given included aggression and being verbally loud or yelling in which R1 was a "definition of impulsive" and demonstrated a "Jackal and Hide kind of thing." She confirmed R1 is allowed to self-propel her wheelchair unsupervised throughout the facility; however, she attempted to keep a closer eye on her when she worked. RN-A described R1's 4/14/22 incident with R3 and explained R1 "yelled" at R3 to sit down or she was going to "smack" him. RN-A indicated R1 became "agitated by the situation and her environment"</p> |                                                                            |  | F 600                                                                                          |                                                                                                                          |                                                                        |                            |



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| F 600                                                            | <p>Continued From page 10</p> <p>when R3's chair alarm continued to engage with his attempted self-transfers. RN-A was unsure as to why she failed to follow-up with management about the episodes she witnessed when R1 verbally and physically abused other residents.</p> <p>During interview on 5/24/22, at 1:43 p.m. R2 stated R1 hit her in the past: "just once" "maybe twice." She acknowledged she lacked remembrance of specific details related to the incident with R1; however, she commented it occurred "maybe the other day. I think it was around 5:00 p.m." R2 explained she avoided R1 "because she hit me;" however, continued, "She tells me what to do" and she does not like when R1 does that. She felt "bad" when the incident occurred; however, felt "better" currently and denied signs or symptoms of physical or psychological harm related to the incident.</p> <p>During interview on 5/24/22, at 1:48 p.m. licensed practical nurse (LPN)-B stated "[R1] has been stopped from slapping others before" and R1's aggressive behaviors have occurred "longer than a few weeks." She identified, "There are things [R1 behaviors] that I have not charted on" as "no one was injured." LPN-B stated if R1 was physically or verbally abusive to other residents "there needs to be a report;" however, she continued, "If [R1] was threatening to slap another resident I would not report that to the state [SA]." She explained R1's behavior monitoring was initiated when R1's behaviors started to escalate and one of her main concerns was directed at documenting R1's escalated behaviors for assist with medication management, not reporting to management every behavior R1 exhibited. LPN-B explained, on 5/13/22 when she entered the lobby, R1 was</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET</b><br><b>BELGRADE, MN 56312</b>                           |  |                                                                        |
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| F 600                                                            | <p>Continued From page 11</p> <p>hitting R2 with an article of clothing. NA-A stopped the "immediate action;" however R1 stood and continued to swing her arms at NA-A as R1 tried to get to R2 "which was unsafe." She confirmed she did not investigate the incident any further after R1 and R2 left the lobby, nor did she assess R1 or R2 for injury or mood changes, update R2's representative or physician, update R1's plan of care to mitigate further abuse or document a progress note in R2's chart. LPN-B explained, "[R2] was scared but she was okay. I am confident she did not suffer any physical harm; but, I did not do an assessment to ensure that: If something would have happened, [R2] would have let me know; If the nursing assistant would have seen anything she would have told me also." She identified the interventions centered around separating R1 and R2 and to re-direct R1 to sit in her wheelchair so she did not fall. She denied she assisted with a comprehensive assessment/analysis process of R1's behaviors.</p> <p>During interview on 5/24/22, at 3:51 p.m. LPN-A stated physical abuse occurred when one resident hit another with a newspaper. She explained, on 5/11/22, R1 "was having a bad night" and wheeled around and slapped other residents on the back, pushed them out of the way, and hit R6 with a rolled up newspaper "a few times." LPN-A indicated R6 "put her arms up in defense." She could not recall if she reported the incident to management and denied she filed a report with the SA, "No one told me to." She explained R1's behaviors were monitored at that time and for R1 "it [aggressive behavior] was nothing out of the ordinary ...that is what she does." "I did not view that as something I needed to report to state [SA]." She verbalized the only</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| F 600                                                            | <p>Continued From page 12</p> <p>intervention implemented that evening was staff sat with R1 until she calmed down, fed her at supper, and put her to bed after. She denied she assessed R1 or R2 for injury: "[R6] had on a really bulky sweater with a sweatshirt on underneath." She explained R2's skin was "paper thin" and R1 "does not have the strength to hurt." She identified "the important thing was to get them separated."</p> <p>When interviewed on 5/24/22, at 2:50 p.m. NA-A confirmed when she entered the lobby on 5/13/22 she witnessed R1 standing in front of R2 in which R1 held onto baby cloths and "was hitting [R2] with it" while R1 yelled at R2. NA-A explained she approached R1 and R2 and got between them where she placed her arms around R1 "like I was hugging her." R1 started to hit NA-A and continue to yell at R2. After LPN-B arrived, she directed R2 to her room and LPN-B went behind R1 and together they coaxed R1 to sit down. NA-A denied she witnessed R1 physically abuse other resident prior to this; however, she indicated she was aware of such events. She explained R1 is "impulsive" and "can be fine one moment and agitated the next." Further, she explained R1 "yells at other residents every day" and "gets in their faces." She acknowledged R1's behaviors were escalated; however, she denied knowledge of any new interventions put into place to mitigate R1's aggressive behaviors towards other residents.</p> <p>During interview on 5/24/22, at 3:59 p.m. the medical director (MD) identified he provided primary physician care to R1. He confirmed he lacked knowledge of the degree to which R1's increased verbal and physical aggression were directed at other residents, even after staff</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| F 600                                                            | <p>Continued From page 13</p> <p>discussed R1's behavioral status with him that afternoon and commented he was on vacation and returned 5/20/22. He explained he preferred to attempt behavior monitoring when behaviors exhibited and then based on that information medication orders would be initiated if needed. When questioned on his expectation for abuse follow-up, he stated he was unsure what his expectations were as he did not know what the facility policy directed staff to do. He denied he was involved in a comprehensive assessment/analysis of R1's aggressive behaviors. He indicated he was unable to comment if examples of R1's behaviors were abuse or not when presented to him, in which he followed up with, "All [residents] are vulnerable adults already" and did not know why all episodes of abuse would need to be reported [to the SA].</p> <p>When interviewed on 5/25/22, at 10:25 a.m. R4 stated he felt safe in the facility and denied being involved in any resident-to-resident altercations. He denied a resident yelled or screamed at him and denied a resident threw anything at him in his room. He commented if another resident were to yell at him, he would holler back at them.</p> <p>When interviewed on 5/25/22, at 10:34 a.m. clinical manager RN-B stated abuse occurred when behaviors were directed specifically at a resident from another, which included other residents. She gave examples of verbal threats and hitting. She expected staff to report any episodes of abuse to their immediate supervisor and follow-up per their policy as it was important that information be utilized to determine interventions to mitigate further behaviors and potential resident harm. She stated a body audit/skin assessment would be conducted "if</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| F 600                                                            | <p>Continued From page 14</p> <p>contact" was present and would only assess the one struck as she "would assume the one doing the striking out would not be injured." RN-B denied she updated R1's care plan after R1 demonstrated escalated behaviors. She explained R1 does not target specific residents "just whoever is convenient at the time." In addition, she confirmed she did not comprehensively assess residents for abuse risk related to their vulnerability factor(s) and thus she did not initiate care plans for abuse risk.</p> <p>When interviewed on 5/25/22, at 11:07 a.m. social services designee (SSD) acknowledged she was only aware of R1's 5/13/22 resident-to-resident SA reported abuse allegation and not aware of the incidents which pertained to R1 being verbally and physically aggressive to other residents prior to that: "I know she does become upset with cares when approached but not toward other residents." After R1's behaviors were discussed, SSD confirmed R1's resident-to-resident verbal and physical aggression was considered abuse and should have been reported and followed-up on per their policy. The SSD denied R1's behaviors and interventions were comprehensively assessed or analyzed after the 5/13/22 incident. Further, she confirmed residents were not comprehensively assessed for abuse risk related to their vulnerability factor(s) and thus care plans for abuse risk were not initiated.</p> <p>During interview via telephone on 5/25/22, at 11:52 a.m. FM-C denied knowledge R4 was involved in a resident-to-resident altercation where another resident threw something at him. FM-C explained she expected to be updated with such events and commented, "I am very angered</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| F 600                                                            | <p>Continued From page 15</p> <p>by this. If staff would have followed up on it appropriately, I would have been called."</p> <p>When interviewed via telephone on 5/25/22, at 12:03 p.m. FM-D denied knowledge R3 was involved in a resident-to-resident altercation where another resident threatened him. FM-D explained she would like to be called if such incidents occurred.</p> <p>During interview via telephone on 5/25/22, at 12:14 p.m. activity director (AD) stated verbal abuse included name calling, using a shaming tone of voice, mocking someone, belittling someone or words that would make someone feel uncomfortable. AD explained R1's "mocking" behavior on 3/30/22 may have been directed at R6; however, she was not totally certain and she also could not remember the words R1 verbalized towards the other residents. "I think a lady said something and [R1] went back at her." AD identified she was expected to report abuse to "the person in charge" and if the abuse caused harm then she was expected to report it "right away." She explained she did not report R1's mocking behavior to the person in charge as she was able to stop the behavior and "did not feel it was blowing out of proportion."</p> <p>When interviewed on 5/25/22, at 12:41 p.m. the director of nursing (DON) stated she expected staff to complete an incident report for all episodes of abuse. She identified examples of abuse occurred when a resident was targeted by someone else, screamed or hollered at, threaten, or hit; however, she commented "so much of it depends [on what is considered abuse]" when a resident diagnosed with dementia is involved in resident-to-resident behavioral</p> | F 600                                                                      |                                                                                                                          |  |                                                                    |



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| F 600                                                            | <p>Continued From page 16</p> <p>interactions. Further, she explained her staff expectations for resident-to-resident abuse follow-up investigation also depended on the situation, the results of the initial investigation and if the allegation was witnessed or not. The DON explained her expectations related to injury assessment centered around staff visualizing the area where the resident stated they were hit or the area staff visualized was hit and she did not expect a full body audit/assessment to be completed or formally documented: a progress note was only required. The DON stated staff resident progress note documentation of resident-to-resident behavioral interactions "depends if back and forth or one sided." If both residents were abusive to each other than a progress note was expected for both residents and if only one resident was the abuser then only that resident had a progress note completed. Continued expectations required staff to notify herself, the administrator, the physician, and the resident contact when abuse was witnessed or alleged. She denied R1's behaviors were comprehensively assessed/analyzed and documented after R1 was determined to have escalated behaviors and demonstrated such behaviors. Further, she denied R1's care plan was reviewed and interventions implemented and reviewed to ensure approaches in place to protect other residents from R1's verbal and physically aggressive behaviors: "We just remove [R1] out of areas." In addition, the DON confirmed residents were not comprehensively assessed for abuse risk related to their vulnerability factor(s) and thus care plans for abuse risk were not initiated: " ...everyone is considered a vulnerable adult."</p> <p>A policy Abuse Policy &amp; Procedure, dated</p> | F 600                                                                      |                                                                                                                          |  |                                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET</b><br><b>BELGRADE, MN 56312</b>                           |  |                                                                    |
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| F 600                                                            | Continued From page 17<br>12/8/20, identified "It is the policy of the Belgrade Nursing Home that each resident will be free from Abuse." Abuse included verbal and physical abuse in which residents would be protected from abuse while they resided at the facility. The policy directs staff to report witnessed or suspected resident abuse immediately to the nurse on duty and management in order for the abuse to be promptly and thoroughly investigated. In the instance of resident-to-resident abuse, the policy identified ensuring the safety and well-being for the vulnerable individual was of utmost priority which included a staff member to remain with the perpetrator resident until further instruction from administration. The policy further directs staff to examine, assess, and notify medical providers as soon as possible to determine any injury and identify any immediate clinical interventions necessary. | F 600                                                                      |                                                                                                                          |  |                                                                    |
| F 604<br>SS=D                                                    | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<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                                                                                                                                                                                                                                           | F 604                                                                      |                                                                                                                          |  | 6/9/22                                                             |



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| F 604                                                            | <p>Continued From page 18</p> <p>any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure 1 of 1 residents (R1) was free from restraint (restricts the resident's freedom of movement or normal access to his/her body) use. In addition, the facility failed to obtain a physician order and assess R1 immediately after a restraint was discontinued, failed to provide supporting pre and post-intervention documentation for the use of a restraint, and failed to immediately notify R1's representative of restraint use when R1 was placed in a manual physical hold.</p> <p>Findings include:</p> <p>R1's significant change Minimum Data Set (MDS) dated 3/31/22, identified R1 was severely cognitively impaired, sometimes understood others and sometimes others understood her. R1 required extensive physical assist with mobility and displayed one to three days of physical behaviors. Diagnosis included dementia, Alzheimers Disease, and Parkinson's Disease.</p> |                                                                            |  | F 604                                                                                          | <p>LPN-B on 5/25/2022 and NA on 5/26/2022 were counseled, re-educated, and shown demonstration on alternative approaches/interventions for residents with behaviors, including a verbal review of the Abuse and Physical Restraint Policies.</p> <p>All current residents were reviewed, and none were found to be subject to a physical restraint.</p> <p>A verbal review of the Abuse and Physical Restraint policies was conducted at the Nurse and Aide meetings as well as re-education and demonstration on alternative approaches/interventions for residents with behaviors.</p> <p>The Director of Nursing or designee will review progress notes for use of physical restraints and report findings to IDT, and report to QA committee quarterly.</p> |                                                                    |                            |



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| F 604                                                            | <p>Continued From page 19</p> <p>A Facility Reported Incident (FRI) submitted to the Stage Agency (SA) on 5/13/22, at 9:16 p.m. identified the following occurred at 7:48 p.m.: "[R1] physically went after [R2]. [R2] began screaming and yelling for help. When the [nursing assistant - NA] arrived on scene she witnessed [R1] hitting [R2] with clothing. [NA] then tried to stop [R1], then [R1] physically went after [NA], hitting, kicking and screaming at [NA], [R1] still trying to get past [NA] to get to [R2]. Nurse arrived on scene shortly after [NA] and instructs [R2] to go to their room while attempting to redirect [R1] and return [R1] to their wheelchair, [R1] had to be physically restrained from hitting [NA] and [R2]. [R1] was then again attempted to be redirected, but she continued to be angry and look for people to go after. [R2] did leave the room when asked."</p> <p>Facility records lacked documented evidence of the following:</p> <ul style="list-style-type: none"> <li>-An immediate order from R1's medical provider, or on-call physician, was obtained for the use of the restraint after the manual physical hold was discontinued.</li> <li>-Attempted interventions and response(s) to those interventions prior to the application of the manual physical hold.</li> <li>-The restraint was the last resort to protect R1's and other residents safety.</li> <li>-R1 was assessed for injury after the manual physical hold was discontinued.</li> <li>-R1 was assessed by staff and R1's medical provider to address other interventions that identified symptoms or cause of the situation.</li> <li>-R1's resident representative was immediately notified of the symptoms and temporary use of the manual physical hold intervention.</li> </ul> | F 604                                                                      |                                                                                                                          |  |                                                                        |



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| F 604                                                            | <p>Continued From page 20</p> <p>-Care planned restraint interventions.</p> <p>When interviewed via telephone on 5/24/22, at 12:22 p.m. R1's representative (FM)-A stated she knew R1's behaviors were escalated and identified the facility contacted her after an episode where R1 "was not very nice to another resident" and R1 required an order for Seroquel. FM-A was contacted again shortly after when the facility called and updated her "[R1] had another bad episode" and needed an order for intramuscular (IM) Haldol (antipsychotic medication). FM-A denied staff updated her that on 5/13/22, R1 required a restraint related to a resident-to-resident altercation.</p> <p>During interview on 5/24/22, at 1:48 p.m. LPN-B indicated when initially asked about facility restraint use, that she personally physically restrained a resident at the facility. She confirmed R1 to be that resident. She explained when she entered the lobby R1 was hitting R2 with an article of clothing. NA-A stopped the "immediate action;" however R1 stood and continued to swing her arms at NA-A as R1 tried to get to R2 "which was unsafe." LPN-B verbally and physically explained how she restrained R1 and assisted her into her wheelchair. She identified she placed R1's wheelchair behind R1 and when R1 brought her arms down LPN-B took her own arms and "looped" R1's arms behind R1's back "just long enough to get her to sit down ...[R1] was not even restrained for a minute." When LPN-B was questioned on facility expectations when a restraint was utilized, she stated an order was required. She confirmed she did not obtain an order, she did not notify management or R1's family she utilized a restraint on R1, she did not assess R1 for injury related to the technique she</p> | F 604                                                                      |                                                                                                                          |  |                                                                        |



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| F 604                                                            | <p>Continued From page 21</p> <p>used, she did not investigate the incident any farther, and did not update R1's plan of care. She identified the interventions prior to the restraint use centered around separating R1 and R2 and to re-direct R1 to sit in her wheelchair so she did not fall.</p> <p>When interviewed on 5/24/22, at 2:50 p.m. NA-A confirmed when she entered the lobby on 5/13/22, she witnessed R1 standing in front of R2 in which R1 held onto baby cloths and "was hitting [R2] with it" while R1 yelled at R2. NA-A explained she approached R1 and R2 and got between them where she placed her arms around R1, "like I was hugging her." R1 started to hit NA-A and continue to yell at R2. After LPN-B arrived, she directed R2 to her room and LPN-B went behind R1 and together they coaxed R1 to sit down. NA-A explained R1 sat in her wheelchair after she assumed LPN-A grabbed the back of R1's pants, "It felt kind of like she was guided backwards and then plopped into the wheelchair." She denied she visualized LPN-B's arms at the time R1 was assisted to sit.</p> <p>During interview on 5/24/22, at 3:59 p.m. the medical director (MD) identified he provided primary physician care to R1 and he stated a physical restraint would be a last resort if there was a risk of resident injury. He indicated he was unable to comment on his restraint expectations for facility staff as he "was not there" and lacked knowledge of the facility's restraint policy. Further, he denied knowledge R1 required a restraint during the 5/13/22 resident to resident incident.</p> <p>When interviewed on 5/25/22, at 10:34 a.m. clinical manager RN-B stated she initially thought R1 was not restrained when LPN-B assisted R1</p> | F 604                                                                      |                                                                                                                          |  |                                                                        |



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| F 604                                                            | <p>Continued From page 22</p> <p>back into her wheelchair on 5/13/22. She denied she was involved in the incident investigation. After RN-B was physical explained LPN-B's technique, she exclaimed, "Oh my gosh, that is not okay." She stated she expected staff to follow a restraint use process to determine if the restraint was necessary and what could have been done differently so as not to restrain that person, determine if there was immediate harm or danger to the resident(s), report the restraint use to the director of nursing (DON), update the doctor and obtain an order, and update the care plan. Further, she denied knowledge of the facility's restraint policy and directed processes; however, she indicated she restraint use should be discussed with "management" and the "nurse involved."</p> <p>During interview on 5/25/22, at 11:07 a.m. social services designee (SSD) stated during her part into R1 and R2's 5/13/22 abuse report, she interviewed LPN-B via a telephone call in which LPN-B verbally explained she physically restrained R1 from hitting; however, LPN-B indicated she grabbed R1 around her waist and sat her on the chair. SSD denied she followed up with LPN-B once LPN-B returned to work for a physical explanation. She explained during her investigation she lacked an "alarming thought" about the maneuver; however, after the maneuver was physically explained to her by the surveyor, she acknowledged concern "because she was not able to release herself from that position, even if a matter of five seconds ...We definitely need to do some behavioral intervention education on this not being your initial response." The SSD denied R1's behaviors and interventions were comprehensively assessed or analyzed after the 5/13/22 resident to resident incident.</p> | F 604                                                                      |                                                                                                                          |  |                                                                        |



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| F 604                                                            | <p>Continued From page 23</p> <p>When interviewed on 5/25/22, at 12:41 p.m. the DON stated an emergency restraint may be necessary "if a resident is swinging at someone's face" or "if they continue to try to go through you to get to another resident." The DON explained if an emergency restraint was required, a nurse may "not necessarily" need to document all actions taken prior and after the event "unless you had to do a bear hug hold like children who need to calm down. We do not do that here however." Updating the doctor would take "something drastic," such as, "you had to take someone to the ground." The DON explained based on LPN-B's verbal explanation of the manual hold during the initial facility investigation that LPN-B only placed her arms around R1's mid-section and assisted her back into the wheelchair. She denied LPN-B demonstrated the manual hold at that time. After the technique used by LPN-B on R1 was physically explained to the DON, the DON acknowledged the manual hold was considered a restraint "for a short period of time, probably." Further, she stated, based on the new understanding, she expected R1's chart to indicate exactly what the staff's actions were pre and post the manual hold, that R1's doctor was updated "right after the progress note" was written, R1 and her range of motion were assessed for any signs of injury, and R1's representative was notified about the incident and interventions required. The DON denied R1's behaviors and interventions were comprehensively assessed or analyzed after the 5/13/22 resident to resident incident.</p> <p>A policy Resident Physical Restraint, dated 3/29/22, identified a physical restraint was any manual method attached or adjacent to the</p> | F 604                                                                      |                                                                                                                          |  |                                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET</b><br><b>BELGRADE, MN 56312</b>                                                                                                                                                                                                                                                                  |  |                                                                    |
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| F 604                                                            | Continued From page 24<br>resident that the resident could not easily remove<br>and that restricted freedom of movement or<br>normal access to their body. The policy directed<br>staff to consider alternatives to restraints "before<br>applying any kind of physical restraint," in which<br>the alternatives and their responses "need to be<br>documented." Examples of alternative<br>interventions was provided. In addition, the policy<br>directed staff to obtain a restraint order, along<br>with representative notification.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | F 604                                                                      |                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                    |
| F 607<br>SS=C                                                    | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and<br>implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse,<br>neglect, and exploitation of residents and<br>misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures<br>to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at<br>paragraph §483.95,<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on interview and document review the<br>facility failed to implement and follow their abuse<br>policy related to implementing resident<br>assessment and abuse prevention, investigation,<br>and reporting for 1 of 1 residents (R1) who had<br>multiple incidents of resident to resident abuse<br>involving multiple residents (R2, R3, R4, R5, R6) .<br>This had the potential to adversely affect all 28<br>residents who resided in the facility.<br><br>Findings include: | F 607                                                                      |                                                                                                                                                                                                                                                                                                                                                                 |  | 7/1/22                                                             |
|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | Abuse policy was reviewed and per<br>facility policy it lacked a<br>Vulnerability/Abuse Risk Assessment.<br><br>Currently, no residents have a<br>Vulnerability/Abuse Risk Assessment.<br>Facility will develop and implement.<br><br>Vulnerability/Abuse Risk Assessment to<br>be done on current residents, new<br>admissions, and at least yearly thereafter |  |                                                                    |



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| F 607                                                            | <p>Continued From page 25</p> <p>A policy Abuse Policy &amp; Procedure, dated 12/8/20, indicated every resident was unique and may be subject to abuse. A component of abuse prevention identified "Upon admission and periodically after that, each resident will have a safety or vulnerability assessment completed which identified potential vulnerability such as cognitive, physical, psychosocial, environment and communication concerns." In addition, the policy identified resident-to-resident altercation investigation processes. The processes included, but was not limited to, the following: prompt reporting of incident occurrences to the nurse supervisor, director of nursing (DON), and administrator; identify event circumstances, notification to each resident's representative and attending physician; event review to include interventions to prevent incident reoccurrence; attending physician consult to identify treatable conditions that may have caused or contributed to the problem; care plan approach adjustments to any or all of the involved residents; document in the resident's clinical record all interventions and their effectiveness; consult psychiatric services as needed; Report of Incident/Accident form completion and document findings; resident transfer as needed; report incidents, findings and corrective measures to appropriate agencies as outlined in the policy.</p> <p>R1's significant change Minimum Data Set (MDS) dated 3/31/22, identified R1 was severely cognitively impaired. R1 displayed one to three days of physical behaviors. Diagnosis included dementia, Alzheimers Disease (form of dementia), and Parkinson's Disease.</p> <p>R1's care plan, printed 5/24/22, identified the</p> | F 607                                                                      | <p>on all residents.</p> <p>Social Services or designee will monitor for compliance of Vulnerability/Abuse Risk Assessment being completed and report to QA committee quarterly.</p> |  |                                                                        |



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| F 607                                                            | <p>Continued From page 26</p> <p>following information:</p> <p>-Revised 5/17/22, R1 has a history of delusional (fixed/false beliefs) thoughts related to dementia secondary to Parkinson's disease with "rapid changes in mood and behaviors without definitive cause." Interventions direct staff to not argue with R1; offer simple direct explanations; provide distraction and reorient as she allows; provide reassurance as needed; remove from areas and attempt to calm with one on one activities.</p> <p>-Revised 12/29/21, R1 has potential to be physically aggressive due to advanced cognitive loss with episodes of hitting, kicking, swinging out at staff and residents. Goal identified R1 would have fewer than three episodes of physical abuse per month. Interventions directed staff in communication techniques; when R1 becomes agitated, intervene before it escalated, guide her away from source of distress, if response is aggressive staff walk calmly away and approach later;</p> <p>-Initiated 4/13/21, R1 has dementia with impaired cognitive function, short/long term memory loss, and impaired thought process. Interventions direct staff to use R1's preferred nickname, identify themselves at each interaction, face R1 when speaking and make eye contact, reduce any distractions; engage R1 in simple structured activities that ovoid overly demanding tasks; break tasks into one step at a time.</p> <p>R1's record identified R1's verbal and physical aggressive behaviors directed towards residents increased around 3/30/22, in which R1 was documented to demonstrate multiple occurrences of verbal and physical aggression towards other residents; however, facility records lacked evidence of further identification, assessment, and notification processes for the residents who</p> | F 607                                                                      |                                                                                                                          |  |                                                                        |



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| F 607                                                            | <p>Continued From page 27</p> <p>were and might have been effected by R1's verbally and physically abusive behaviors. In addition, there was no evidence of ongoing protection plans for all residents potentially affected. Furthermore, R1's record did not include a completed comprehensive analysis/evaluation of verbal and/or physical behaviors and/or effectiveness of behavioral interventions to determine if R1 required new interventions as a result of the increased behaviors in order to mitigate further episodes of verbal and physical aggression. R1's record lacked evidence R1's primary physician was updated on R1's increased verbal and physical aggression prior to 5/13/22. In addition, facility records lacked evidence staff updated management related to R1's witnessed resident-to-resident abuse which resulted in each witnessed allegation not investigated and reported per facility policy.</p> <p>R1's progress note, dated 3/30/22, at 7:27 a.m. identified R1 was "mocking" her tablemates at supper the previous evening.</p> <p>R1's progress note, dated 4/14/22, at 10:01 p.m. identified R1 entered R4's room and after R4 raised his voice and told R1 to leave, "She started screaming at him and waving both arms, pointing and getting increasingly agitated. [R4] then yelled back and was going to shut his bedroom door when [R1] threw her partial glass of Ensure (nutritional supplement) at [R4] ..." After the incident, R1 "calmed" for short periods; however, displayed "quick, intense outbursts of anger, yelling, and being short with other residents ... After the incident, R1 threatened to "smack" R3, who was located in the lobby, if he stood up again.</p> | F 607                                                                      |                                                                                                                          |  |                                                                        |



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| F 607                                                            | <p>Continued From page 28</p> <p>R4's annual MDS dated 3/4/22, identified R4 was diagnosed with dementia and was severely cognitively impaired. R4's progress note, dated 4/14/22, at 10:07 p.m. identified the interaction with R1.</p> <p>R3's quarterly MDS dated 3/23/22, identified R3 was diagnosed with dementia and was severely cognitively impaired.</p> <p>R1's progress note, dated 4/15/22, at 1:33 p.m. identified R1 "was very anxious this shift" in which she "yelled" at other residents.</p> <p>A physician's communication form, dated 4/22/22, updated R1's neurologist R1 was "impulsive and becomes fixated on things at times ...delusional at times." Communication form lacked any update on R1's verbal/physical aggression towards other residents.</p> <p>A dictated Minneapolis Clinic of Neurology progress note, dated 4/22/22, identified R1 was seen, in person, by neurology. R1's history of present illness (HPI) indicated "for the past few months" she demonstrated delusions (fixed/false beliefs) and was more confused and disoriented about time and space. "So far she still can be directed. No agitation or aggressive behavior." The physician suggested the facility continue "behavior justification and try redirecting. If not helping, will consider Seroquel (antipsychotic medication) 12.5 milligrams (mg) as needed."</p> <p>R1's progress note, dated 4/23/22, at 7:32 p.m. identified R1 was "yelling" at other resident(s) and "appeared very agitated this shift."</p> <p>R1's progress note, dated 4/25/22, at 8:50 p.m.</p> | F 607                                                                      |                                                                                                                          |                            |                                                                        |



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| F 607                                                            | <p>Continued From page 29</p> <p>identified R1 was "hitting another resident [R5]."</p> <p>R5's significant change MDS dated 5/19/22, identified R5 was diagnosed with dementia and depression and was severely cognitively impaired.</p> <p>R1's progress note, dated 5/1/22, at 8:04 p.m. identified R1 was "attempting to scold other residents ..."</p> <p>R1's progress note, dated 5/6/22, at 8:31 p.m. identified R1 was "verbally aggressive with other residents."</p> <p>R1's progress note, dated 5/11/22, at 9:14 p.m. identified R1 wheeled up to other residents and hugged them from behind and was "hollering" at them when she said something to them and they did not answer or she could not hear them. Further, [R1] wheeled up to R6 and "slapped" R6 five times with a rolled up newspaper.</p> <p>R6's quarterly MDS dated 2/24/22, identified R6 was diagnosed with Alzheimer's Disease and was severely cognitively impaired.</p> <p>R1's progress note, dated 5/13/22, at 9:36 p.m. identified LPN-B, after she responded to screaming and yelling from the lobby, witnessed NA attempting to stop R1 from hitting R2 with articles of baby clothing. R1 became combative with NA. R2 yelled "she was hitting me!" R2 was asked to go her room, which she did. R1 continued to try and make contact with R2 as she hit and kicked at NA. LPN-B "then got behind [R1] and put her arms beck [sic] her back and assisted her back into her wheelchair."</p> | F 607                                                                      |                                                                                                                          |  |                                                                        |



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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245418</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>05/25/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET</b><br><b>BELGRADE, MN 56312</b>                           |  |                                                                        |
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| F 607                                                            | <p>Continued From page 30</p> <p>R2's quarterly MDS dated 3/24/22, identified R2 was moderately cognitively impaired.</p> <p>R1's progress note, dated 5/15/22, at 9:58 p.m. identified R1 "has been up and down with behaviors" in which she swung out and slapped at other residents.</p> <p>R1's progress note, dated 5/23/22, at 7:34 p.m. identified R1 was "yelling at other residents in the dining room."</p> <p>R1's resident-to-resident altercation progress notes, dated 3/20/22, 4/15/22, 4/23/22, 5/1/22, 5/6/22, 5/15/22, 5/23/22, lacked documented evidence of the involved resident(s), investigation processes performed, or facility management notification.</p> <p>R1's resident-to-resident altercation progress notes, dated 4/14/22, 4/25/22, 5/11/22, 5/23/22, lacked documented evidence of the investigation processes performed or facility management notification.</p> <p>R1, R2, R3, R4, R5, and R6's medical records were reviewed and lacked evidence of a safety/abuse/vulnerability assessment which identified their abuse risk. These assessments were requested. None were provided.</p> <p>R1, R2, R3, R4, R5, and R6's care plans were reviewed and lacked a safety/abuse/vulnerability plan of care with associated goals and interventions to decreased abuse risk.</p> <p>R2, R3, R5, and R6's medical records were reviewed and each lacked documented evidence of their witnessed resident-to resident</p> | F 607                                                                      |                                                                                                                          |  |                                                                        |



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| F 607                                                            | <p>Continued From page 31</p> <p>altercation(s) with R1 following the incident(s).</p> <p>Event (Incident) Risk Management reports were requested for R2, R3, R4, R5, and R6 which identified investigation and follow-up related to R1's resident-to-resident behavioral interactions with them. None were provided.</p> <p>During interview via telephone on 5/24/22, at 12:22 p.m. R1's representative (FM)-A stated she knew R1's behaviors were escalated and identified the facility contacted her after an episode where R1 "was not very nice to another resident." FM-A was contacted again shortly after when the facility called and updated her "[R1] had another bad episode." FM-A confirmed R1 hollered out at times in the dining room, hit out at staff and pinched her personally in the past; however, she denied knowledge R1 was combative to other residents.</p> <p>When interviewed via telephone on 5/24/22, at 12:40 p.m. FM-B acknowledged she was not aware R2 was involved in a resident-to-resident altercation on 5/13/22. She explained she expected a phone call if such an event occurred: "I am surprised I never got one [phone call]."</p> <p>When interviewed on 5/24/22, at 12:53 p.m. registered nurse (RN)-A explained R1's "dementia and disease process has gradually gotten further into it and we are seeing more behaviors with her." Examples given included aggression and being verbally loud or yelling in which R1 was a "definition of impulsive" and demonstrated a "Jackal and Hide kind of thing." She confirmed R1 is allowed to self-propel her wheelchair unsupervised throughout the facility; however, she attempted to keep a closer eye on</p> | F 607                                                                      |                                                                                                                          |  |                                                                        |



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| F 607                                                            | <p>Continued From page 32</p> <p>her when she worked. RN-A was unsure as to why she failed to follow-up with management about the episodes she witnessed when R1 verbally and physically abused other residents.</p> <p>During interview on 5/24/22, at 1:48 p.m. licensed practical nurse (LPN)-B stated "[R1] has been stopped from slapping others before" and R1's aggressive behaviors have occurred "longer than a few weeks." She identified, "There are things [R1 behaviors] that I have not charted on" as "no one was injured." LPN-B stated if R1 was physically or verbally abusive to other residents "there needs to be a report;" however, she continued, "If [R1] was threatening to slap another resident I would not report that to the state [SA]." She explained R1's behavior monitoring was initiated when R1's behaviors started to escalate and one of her main concerns was directed at documenting R1's escalated behaviors for assist with medication management, not reporting to management every behavior R1 exhibited. LPN-B explained, on 5/13/22 when she entered the lobby, R1 was hitting R2 with an article of clothing. She confirmed she did not investigate the incident any further after R1 and R2 left the lobby, nor did she assess R1 or R2 for injury or mood changes, update R2's representative or physician, update R1's plan of care to mitigate further abuse or document a progress note in R2's chart. LPN-B explained, "[R2] was scared but she was okay. I am confident she did not suffer any physical harm; but, I did not do an assessment to ensure that: If something would have happened, [R2] would have let me know; If the nursing assistant would have seen anything she would have told me also." She identified the interventions centered around separating R1 and R2 and to</p> | F 607                                                                      |                                                                                                                          |  |                                                                        |



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| F 607                                                            | <p>Continued From page 33</p> <p>re-direct R1 to sit in her wheelchair so she did not fall. She denied she assisted with a comprehensive assessment/analysis process of R1's behaviors.</p> <p>During interview on 5/24/22, at 3:51 p.m. LPN-A explained, on 5/11/22, R1 "was having a bad night" and wheeled around and slapped other residents on the back, pushed them out of the way, and hit R6 with a rolled up newspaper "a few times." LPN-A indicated R6 "put her arms up in defense." She could not recall if she reported the incident to management and denied she filed a report with the SA, "No one told me to." She explained R1's behaviors were monitored at that time and for R1 "it [aggressive behavior] was nothing out of the ordinary ...that is what she does." "I did not view that as something I needed to report to state [SA]." She verbalized the only intervention implemented that evening was staff sat with R1 until she calmed down, fed her at supper, and put her to bed after. She denied she assessed R1 or R2 for injury: "[R6] had on a really bulky sweater with a sweatshirt on underneath." She explained R2's skin was "paper thin" and R1 "does not have the strength to hurt." She identified "the important thing was to get them separated."</p> <p>During interview on 5/24/22, at 3:59 p.m. the medical director (MD) identified he provided primary physician care to R1. He confirmed he lacked knowledge of the degree to which R1's increased verbal and physical aggression were directed at other residents, even after staff discussed R1's behavioral status with him that afternoon and commented he was on vacation and returned 5/20/22. He explained he preferred to attempt behavior monitoring when behaviors</p> | F 607                                                                      |                                                                                                                          |  |                                                                    |



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| F 607                                                            | <p>Continued From page 34</p> <p>exhibited and then based on that information medication orders would be initiated if needed. When questioned on his expectation for abuse follow-up, he stated he was unsure what his expectations were as he did not know what the facility policy directed staff to do. He denied he was involved in a comprehensive assessment/analysis of R1's aggressive behaviors. He indicated he was unable to comment if examples of R1's behaviors were abuse or not when presented to him, in which he followed up with, "All [residents] are vulnerable adults already" and did not know why all episodes of abuse would need to be reported [to the SA].</p> <p>When interviewed on 5/25/22, at 10:34 a.m. clinical manager RN-B stated she expected staff to report any episodes of abuse to their immediate supervisor and follow-up per their policy as it was important that information be utilized to determine interventions to mitigate further behaviors and potential resident harm. She stated a body audit/skin assessment would be conducted "if contact" was present and would only assess the one struck as she "would assume the one doing the striking out would not be injured." RN-B denied she updated R1's care plan after R1 demonstrated escalated behaviors. She explained R1 does not target specific residents "just whoever is convenient at the time." In addition, she confirmed she did not comprehensively assess residents for abuse risk related to their vulnerability factor(s) and thus she did not initiate care plans for abuse risk.</p> <p>When interviewed on 5/25/22, at 11:07 a.m. social services designee (SSD) acknowledged she was only aware of R1's 5/13/22 resident-to-resident SA reported abuse allegation</p> | F 607                                                                      |                                                                                                                          |  |                                                                        |



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| F 607                                                            | <p>Continued From page 35</p> <p>and not aware of the incidents which pertained to R1 being verbally and physically aggressive to other residents prior to that: "I know she does become upset with cares when approached but not toward other residents." After R1's behaviors were discussed, SSD confirmed R1's resident-to-resident verbal and physical aggression was considered abuse and should have been reported and followed-up on per their policy. The SSD denied R1's behaviors and interventions were comprehensively assessed or analyzed after the 5/13/22 incident. Further, she confirmed residents were not comprehensively assessed for abuse risk related to their vulnerability factor(s) and thus care plans for abuse risk were not initiated</p> <p>During interview via telephone on 5/25/22, at 11:52 a.m. FM-C denied knowledge R4 was involved in a resident-to-resident altercation where another resident threw something at him.</p> <p>When interviewed via telephone on 5/25/22, at 12:03 p.m. FM-D denied knowledge R3 was involved in a resident-to-resident altercation where another resident threatened him.</p> <p>During interview via telephone on 5/25/22, at 12:14 p.m. activity director (AD) explained R1's "mocking" behavior on 3/30/22 may have been directed at R6; however, she was not totally certain and she also could not remember the words R1 verbalized towards the other residents. "I think a lady said something and [R1] went back at her." AD identified she was expected to report abuse to "the person in charge" and if the abuse caused harm then she was expected to report it "right away." She explained she did not report R1's mocking behavior to the person in charge as</p> | F 607                                                                      |                                                                                                                          |  |                                                                        |



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| F 607                                                            | <p>Continued From page 36</p> <p>she was able to stop the behavior and "did not feel it was blowing out of proportion."</p> <p>When interviewed on 5/25/22, at 12:41 p.m. the director of nursing (DON) stated she expected staff to complete an incident report for all episodes of abuse. She identified examples of abuse occurred when a resident was targeted by someone else, screamed or hollered at, threatened, or hit; however, she commented "so much of it depends [on what is considered abuse]" when a resident diagnosed with dementia is involved in resident-to-resident behavioral interactions. Further, she explained her staff expectations for resident-to-resident abuse follow-up investigation also depended on the situation, the results of the initial investigation and if the allegation was witnessed or not. The DON explained her expectations related to injury assessment centered around staff visualizing the area where the resident stated they were hit or the area staff visualized was hit and she did not expect a full body audit/assessment to be completed or formally documented: a progress note was only required. The DON stated staff resident progress note documentation of resident-to-resident behavioral interactions "depends if back and forth or one sided." If both residents were abusive to each other than a progress note was expected for both residents and if only one resident was the abuser then only that resident had a progress note completed. Continued expectations required staff to notify herself, the administrator, the physician, and the resident contact when abuse was witnessed or alleged. She denied R1's behaviors were comprehensively assessed/analyzed and documented after R1 was determined to have escalated behaviors and demonstrated such</p> | F 607                                                                      |                                                                                                                          |  |                                                                    |



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| F 607                                                            | Continued From page 37                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | F 607                                                                      |                                                                                                                          |  |                                                                    |
| F 609<br>SS=E                                                    | <p>behaviors. Further, she denied R1's care plan was reviewed and interventions implemented and reviewed to ensure approaches in place to protect other residents from R1's verbal and physically aggressive behaviors: "We just remove [R1] out of areas." In addition, the DON confirmed residents were not comprehensively assessed for abuse risk related to their vulnerability factor(s) and thus care plans for abuse risk were not initiated: " ...everyone is considered a vulnerable adult."</p> <p>Reporting of Alleged Violations<br/>CFR(s): 483.12(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§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.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in</p> | F 609                                                                      |                                                                                                                          |  | 7/1/22                                                             |



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| F 609                                                            | <p>Continued From page 38</p> <p>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:</p> <p>Based on interview and document review, the facility failed to report allegations of resident-to-resident verbal and physical abuse to the State Agency (SA) within 2 hours of the allegation for at least 5 of 5 residents (R1, R3, R4, R5, R6) reviewed for resident-to-resident abuse.</p> <p>Findings include:</p> <p>R1's significant change Minimum Data Set (MDS) dated 3/31/22, identified R1 was severely cognitively impaired. Diagnosis included dementia and Alzheimers Disease.</p> <p>R3's quarterly MDS dated 3/23/22, identified R3 was diagnosed with dementia and was severely cognitively impaired.</p> <p>R4's annual MDS dated 3/4/22, identified R4 was diagnosed with dementia and was severely cognitively impaired; however.</p> <p>R5's significant change MDS dated 5/19/22, identified R5 was diagnosed with dementia and depression and was severely cognitively impaired.</p> <p>R6's quarterly MDS dated 2/24/22, identified R6 was diagnosed with Alzheimer's Disease and was severely cognitively impaired.</p> <p>Facility records lacked evidence the following</p> | F 609                                                                      | <p>A verbal review of the Abuse Policy was conducted at the Nurse and Aide meetings as well as re-education on reporting suspected abuse immediately to their supervisor and within 2 hours to the State Agency, focusing on Resident-to-Resident Abuse.</p> <p>The past 3 months of allegations of abuse reports were reviewed and found they were all reported in a timely manner; however, 10 incidents documented in R1's progress notes of verbal and physical abuse toward other residents were not reported to the State Agency.</p> <p>All 10 unreported incidents involving R1 will be reported due to alleged verbal and/or physical abuse after complaint survey was conducted by State Agency.</p> <p>The Director of Nursing or designee will review documentation and monitor all allegations of abuse to assure they are being reported to the State Agency, and report to QA committee quarterly.</p> |  |                                                                    |



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| F 609                                                            | <p>Continued From page 39</p> <p>incidents were reported to the SÄ:</p> <p>R1's progress note, dated 4/14/22, at 10:01 p.m. identified R1 entered R4's room and after R4 raised his voice and told R1 to leave, "She started screaming at him and waving both arms, pointing and getting increasingly agitated. [R4] then yelled back and was going to shut his bedroom door when [R1] threw her partial glass of Ensure (nutritional supplement) at [R4] ..." After the incident, R1 "calmed" for short periods; however, displayed "quick, intense outbursts of anger, yelling, and being short with other residents ... After the incident, R1 threatened to "smack" R3, who was located in the lobby, if he stood up again.</p> <p>R1's progress note, dated 4/25/22, at 8:50 p.m. identified R1 was "hitting another resident [R5]."</p> <p>R1's progress note, dated 5/6/22, at 8:31 p.m. identified R1 was "verbally aggressive with other residents."</p> <p>R1's progress note, dated 5/11/22, at 9:14 p.m. identified R1 wheeled up to other residents and hugged them from behind and was "hollering" at them when she said something to them and they did not answer or she could not hear them. Further, [R1] wheeled up to R6 and "slapped" R6 five times with a rolled up newspaper.</p> <p>R1's progress note, dated 5/15/22, at 9:58 p.m. identified R1 "has been up and down with behaviors" in which she swung out and slapped at other residents.</p> <p>R1's progress note, dated 5/23/22, at 7:34 p.m. identified R1 was "yelling at other residents in the</p> | F 609                                                                      |                                                                                                                          |  |                                                                    |



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| F 609                                                            | <p>Continued From page 40<br/>dining room."</p> <p>When interviewed on 5/24/22, at 12:53 p.m. registered nurse (RN)-A stated verbalized threat(s) directed at others, which was intended to hurt someone else, was a form of verbal abuse. RN-A explained R1 "yelled" at R3 to sit down or she was going to "smack" him. RN-A indicated R1 became "agitated by the situation and her environment" when R3's chair alarm continued to engage with his attempted self-transfers. Further, she acknowledged physical abuse could be demonstrated by throwing things at others. RN-A stated if she witnessed abuse she was expected to report to the SA within two hours "if serious injury" occurred. She was unsure as to why she failed to follow-up with management about the episodes she witnessed when R1 verbally and physically abused other residents.</p> <p>During interview on 5/24/22, at 1:48 p.m. licensed practical nurse (LPN)-B stated "[R1] has been stopped from slapping others before" and R1's aggressive behaviors have occurred "longer than a few weeks." She identified, "There are things [R1 behaviors] that I have not charted on" as "no one was injured." LPN-B stated if R1 was physically or verbally abusive to other residents "there needs to be a report;" however, she continued, "If [R1] was threatening to slap another resident I would not report that to the state [SA]." She explained R1's behavior monitoring was initiated when R1's behaviors started to escalate and one of her main concerns was directed at documenting R1's escalated behaviors for assist with medication management, not reporting to management every behavior R1 exhibited.</p> | F 609                                                                      |                                                                                                                          |  |                                                                        |



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| F 609                                                            | <p>Continued From page 41</p> <p>During interview on 5/24/22, at 3:51 p.m. LPN-A stated physical abuse occurred when one resident hit another with a newspaper. She explained, on 5/11/22, R1 "was having a bad night" and wheeled around and slapped other residents on the back, pushed them out of the way, and hit R6 with a rolled up newspaper "a few times." LPN-A indicated R6 "put her arms up in defense." She could not recall if she reported the incident to management and denied she filed a report with the SA, "No one told me to." She explained R1's behaviors were monitored at that time and for R1 "it [aggressive behavior] was nothing out of the ordinary ...that is what she does." "I did not view that as something I needed to report to state [SA]." LPN-A stated she was expected to report "severe physical" abuse and followed up with, "I do not know about [when to report] verbal abuse."</p> <p>When interviewed on 5/24/22, at 3:59 p.m. the medical director (MD) identified he provided primary physician care to R1. He confirmed he lacked knowledge of the degree to which R1's increased verbal and physical aggression were directed at other residents, even after staff discussed R1's behavioral status with him that afternoon. When questioned on his expectation for abuse reporting, he stated he was unsure what the reporting expectations were as he did not know what the facility policy on reporting directed staff to do. Further, he indicated he was unable to comment if examples of R1's behaviors were abuse or not when presented to him, in which he followed up with, "All [residents] are vulnerable adults already" and did not know why all episodes of abuse would need to be reported [to the SA].</p> | F 609                                                                      |                                                                                                                          |  |                                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET</b><br><b>BELGRADE, MN 56312</b> |                                                                                                                          |                                                                        |                            |
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| F 609                                                            | <p>Continued From page 42</p> <p>During interview on 5/25/22, at 10:34 a.m. clinical manager RN-B stated abuse occurred when behaviors were directed specifically at a resident from another, which included other residents. She gave examples of verbal threats and hitting. She expected staff to report any episodes of abuse to their immediate supervisor as it was important that information be utilized to determine interventions to mitigate further behaviors and potential resident harm.</p> <p>When interviewed on 5/25/22, at 11:07 a.m. social services designee (SSD) acknowledged she was only aware of R1's 5/13/22 resident to resident SA reported abuse allegation and not aware of the incidents which pertained to R1 being verbally and physically aggressive to other residents prior to that. Due to this, R1's verbal and physical resident directed behaviors prior to 5/13/22 were not reported to the SA as per their policy. After R1's behaviors were discussed, SSD confirmed R1's resident directed verbal and physical aggression was considered abuse and should have been reported to the SA "immediately" or "at least within the two hours that is required."</p> <p>During interview on 5/25/22, at 12:14 p.m. activity director (AD) stated verbal abuse included name calling, using a shaming tone of voice, mocking someone, belittling someone or words that would make someone feel uncomfortable. AD explained R1's "mocking" behavior on 3/30/22 may have been directed at R6; however, she was not totally certain and she also could not remember the words R1 verbalized towards the other residents. "I think a lady said something and [R1] went back at her." AD identified she was expected to report</p> |                                                                            |  | F 609                                                                                          |                                                                                                                          |                                                                        |                            |



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

PRINTED: 06/24/2022  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245418</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>05/25/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET</b><br><b>BELGRADE, MN 56312</b>                           |  |                                                                        |
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| F 609                                                            | <p>Continued From page 43</p> <p>abuse to "the person in charge" and if the abuse caused harm then she was expected to report it "right away." She explained she did not report R1's mocking behavior to the person in charge as she was able to stop the behavior and "did not feel it was blowing out of proportion."</p> <p>When interviewed on 5/25/22, at 12:41 p.m. the director of nursing (DON) stated she expected all episodes of abuse to be reported per their policy. She identified examples of abuse occurred when a resident was targeted by someone else, screamed or hollered at, threatens, or hit and she expected the incident to be reported within two hours if the allegation was identified as abuse during the initial investigation process.</p> <p>A policy Abuse Policy &amp; Procedure, dated 12/8/20, defined physical abuse included, but was not limited to, hitting and slapping, and defined verbal abuse as the use of oral or gestured communication or sounds to residents within hearing distance, regardless of ability to understand. The policy identified a procedure for internal reporting which directed "Employees must always report any abuse or suspicion of abuse immediately to the Administrator." Further, the policy directed staff to report all alleged violations of abuse "immediately, but not later than 2 hours after the allegation is made."</p> | F 609                                                                      |                                                                                                                          |  |                                                                        |





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

Electronically delivered  
June 8, 2022

Administrator  
Belgrade Nursing Home  
103 School Street  
Belgrade, MN 56312-0340

Re: State Nursing Home Licensing Orders  
Event ID: 734Z11

Dear Administrator:

The above facility was surveyed on May 24, 2022 through May 25, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](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



Belgrade Nursing Home

June 8, 2022

Page 2

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susie Haben, Rapid Response  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Midtown Square  
3333 Division Street, Suite 212  
Saint Cloud, Minnesota 56301-4557  
Email: [susie.haben@state.mn.us](mailto:susie.haben@state.mn.us)  
Office: (320) 223-7356 Mobile: (651) 230-2334

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,



Joanne Simon, Compliance Analyst  
Minnesota Department of Health  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
Email: [joanne.simon@state.mn.us](mailto:joanne.simon@state.mn.us)

cc: Licensing and Certification File



Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>00626</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                    |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>05/25/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET<br/>BELGRADE, MN 56312</b> |                                                                                                                          |                                                                    |
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| 2 000                                                            | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:<br/>On 5/24/22 - 5/25/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p> | 2 000                                                                                    |                                                                                                                          |                                                                    |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/17/22



Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                          |                                                                                                                          |  |                                                                    |
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| 2 000                                                            | <p>Continued From page 1</p> <p>The following complaint was found to be<br/><b>SUBSTANTIATED: H54181690C (MN00083544)</b><br/>with licensing orders issued at 0520</p> <p>Minnesota Department of Health is documenting<br/>the State Licensing Correction Orders using<br/>Federal software. Tag numbers have been<br/>assigned to Minnesota state statutes/rules for<br/>Nursing Homes. The assigned tag number<br/>appears in the far-left column entitled "ID Prefix<br/>Tag." The state statute/rule out of compliance is<br/>listed in the "Summary Statement of Deficiencies"<br/>column and replaces the "To Comply" portion of<br/>the correction order. This column also includes<br/>the findings which are in violation of the state<br/>statute after the statement, "This Rule is not met<br/>as evidence by." Following the surveyor 's<br/>findings are the Suggested Method of Correction<br/>and Time Period for Correction.<br/>You have agreed to participate in the electronic<br/>receipt of State licensure orders consistent with<br/>the Minnesota Department of Health<br/>Informational Bulletin 14-01, available at<br/><a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a> The State licensing<br/>orders are delineated on the attached Minnesota<br/>Department of Health orders being submitted to<br/>you electronically. Although no plan of correction<br/>is necessary for State Statutes/Rules, please<br/>enter the word "CORRECTED" in the box<br/>available for text. You must then indicate in the<br/>electronic State licensure process, under the<br/>heading completion date, the date your orders will<br/>be corrected prior to electronically submitting to<br/>the Minnesota Department of Health. The facility<br/>is enrolled in ePOC and therefore a signature is<br/>not required at the bottom of the first page of<br/>state form.</p> | 2 000                                                                                    |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

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| 2 000                                                            | Continued From page 2<br><br>PLEASE DISREGARD THE HEADING OF THE<br>FOURTH COLUMN WHICH STATES,<br>"PROVIDER'S PLAN OF CORRECTION." THIS<br>APPLIES TO FEDERAL DEFICIENCIES ONLY.<br>THIS WILL APPEAR ON EACH PAGE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2 000                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                    |
| 2 520                                                            | MN Rule 4658.0300 Subp. 3 B Use of Restraints<br><br>Subp. 3. Emergency use of restraint.<br><br>B. If a restraint is needed, a physician's order<br>must be obtained which specifies the duration<br>and circumstances under which the restraint is to<br>be used.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on interview and document review, the<br>facility failed to ensure 1 of 1 residents (R1) was<br>free from restraint (restricts the resident's<br>freedom of movement or normal access to<br>his/her body) use. In addition, the facility failed to<br>obtain a physician order and assess R1<br>immediately after a restraint was discontinued,<br>failed to provide supporting pre and<br>post-intervention documentation for the use of a<br>restraint, and failed to immediately notify R1's<br>representative of restraint use when R1 was<br>placed in a manual physical hold.<br><br>Findings include:<br><br>R1's significant change Minimum Data Set (MDS)<br>dated 3/31/22, identified R1 was severely<br>cognitively impaired, sometimes understood<br>others and sometimes others understood her. R1<br>required extensive physical assist with mobility<br>and displayed one to three days of physical | 2 520                                                                                    | LPN-B on 5/25/2022 and NA on 5/26/2022<br>were counseled, re-educated, and shown<br>demonstration on alternative<br>approaches/interventions for residents<br>with behaviors, including a verbal review<br>of the Abuse and Physical Restraint<br>Policies.<br><br>All current residents were reviewed, and<br>none were found to be subject to a<br>physical restraint.<br><br>A verbal review of the Abuse and Physical<br>Restraint policies was conducted at the<br>Nurse and Aide meetings as well as<br>re-education and demonstration on<br>alternative approaches/interventions for<br>residents with behaviors.<br><br>The Director of Nursing or designee will<br>review progress notes for use of physical |  | 6/9/22                                                             |



Minnesota Department of Health

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| 2 520                                                            | <p>Continued From page 3</p> <p>behaviors. Diagnosis included dementia, Alzheimers Disease, and Parkinson's Disease.</p> <p>A Facility Reported Incident (FRI) submitted to the Stage Agency (SA) on 5/13/22, at 9:16 p.m. identified the following occurred at 7:48 p.m.: "[R1] physically went after [R2]. [R2] began screaming and yelling for help. When the [nursing assistant - NA] arrived on scene she witnessed [R1] hitting [R2] with clothing. [NA] then tried to stop [R1], then [R1] physically went after [NA], hitting, kicking and screaming at [NA], [R1] still trying to get past [NA] to get to [R2]. Nurse arrived on scene shortly after [NA] and instructs [R2] to go to their room while attempting to redirect [R1] and return [R1] to their wheelchair, [R1] had to be physically restrained from hitting [NA] and [R2]. [R1] was then again attempted to be redirected, but she continued to be angry and look for people to go after. [R2] did leave the room when asked."</p> <p>Facility records lacked documented evidence of the following:</p> <ul style="list-style-type: none"> <li>-An immediate order from R1's medical provider, or on-call physician, was obtained for the use of the restraint after the manual physical hold was discontinued.</li> <li>-Attempted interventions and response(s) to those interventions prior to the application of the manual physical hold.</li> <li>-The restraint was the last resort to protect R1's and other residents safety.</li> <li>-R1 was assessed for injury after the manual physical hold was discontinued.</li> <li>-R1 was assessed by staff and R1's medical provider to address other interventions that identified symptoms or cause of the situation.</li> <li>-R1's resident representative was immediately notified of the symptoms and temporary use of</li> </ul> | 2 520                                                                                    | restraints and report findings to IDT, and report to QA committee quarterly.                                             |  |                                                                    |



Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELGRADE NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 SCHOOL STREET<br/>BELGRADE, MN 56312</b> |                                                                                                                          |  |                                                                    |
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| 2 520                                                            | <p>Continued From page 4</p> <p>the manual physical hold intervention.<br/>-Care planned restraint interventions.</p> <p>When interviewed via telephone on 5/24/22, at 12:22 p.m. R1's representative (FM)-A stated she knew R1's behaviors were escalated and identified the facility contacted her after an episode where R1 "was not very nice to another resident" and R1 required an order for Seroquel. FM-A was contacted again shortly after when the facility called and updated her "[R1] had another bad episode" and needed an order for intramuscular (IM) Haldol (antipsychotic medication). FM-A denied staff updated her that on 5/13/22, R1 required a restraint related to a resident-to-resident altercation.</p> <p>During interview on 5/24/22, at 1:48 p.m. LPN-B indicated when initially asked about facility restraint use, that she personally physically restrained a resident at the facility. She confirmed R1 to be that resident. She explained when she entered the lobby R1 was hitting R2 with an article of clothing. NA-A stopped the "immediate action;" however R1 stood and continued to swing her arms at NA-A as R1 tried to get to R2 "which was unsafe." LPN-B verbally and physically explained how she restrained R1 and assisted her into her wheelchair. She identified she placed R1's wheelchair behind R1 and when R1 brought her arms down LPN-B took her own arms and "looped" R1's arms behind R1's back "just long enough to get her to sit down ...[R1] was not even restrained for a minute." When LPN-B was questioned on facility expectations when a restraint was utilized, she stated an order was required. She confirmed she did not obtain an order, she did not notify management or R1's family she utilized a restraint on R1, she did not assess R1 for injury related to the technique she</p> | 2 520                                                                                    |                                                                                                                          |  |                                                                    |



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| 2 520                                                            | <p>Continued From page 5</p> <p>used, she did not investigate the incident any farther, and did not update R1's plan of care. She identified the interventions prior to the restraint use centered around separating R1 and R2 and to re-direct R1 to sit in her wheelchair so she did not fall.</p> <p>When interviewed on 5/24/22, at 2:50 p.m. NA-A confirmed when she entered the lobby on 5/13/22, she witnessed R1 standing in front of R2 in which R1 held onto baby cloths and "was hitting [R2] with it" while R1 yelled at R2. NA-A explained she approached R1 and R2 and got between them where she placed her arms around R1, "like I was hugging her." R1 started to hit NA-A and continue to yell at R2. After LPN-B arrived, she directed R2 to her room and LPN-B went behind R1 and together they coaxed R1 to sit down. NA-A explained R1 sat in her wheelchair after she assumed LPN-A grabbed the back of R1's pants, "It felt kind of like she was guided backwards and then plopped into the wheelchair." She denied she visualized LPN-B's arms at the time R1 was assisted to sit.</p> <p>During interview on 5/24/22, at 3:59 p.m. the medical director (MD) identified he provided primary physician care to R1 and he stated a physical restraint would be a last resort if there was a risk of resident injury. He indicated he was unable to comment on his restraint expectations for facility staff as he "was not there" and lacked knowledge of the facility's restraint policy. Further, he denied knowledge R1 required a restraint during the 5/13/22 resident to resident incident.</p> <p>When interviewed on 5/25/22, at 10:34 a.m. clinical manager RN-B stated she initially thought R1 was not restrained when LPN-B assisted R1 back into her wheelchair on 5/13/22. She denied</p> | 2 520                                                                                    |                                                                                                                          |  |                                                                    |



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| 2 520                                                            | <p>Continued From page 6</p> <p>she was involved in the incident investigation. After RN-B was physical explained LPN-B's technique, she exclaimed, "Oh my gosh, that is not okay." She stated she expected staff to follow a restraint use process to determine if the restraint was necessary and what could have been done differently so as not to restrain that person, determine if there was immediate harm or danger to the resident(s), report the restraint use to the director of nursing (DON), update the doctor and obtain an order, and update the care plan. Further, she denied knowledge of the facility's restraint policy and directed processes; however, she indicated she restraint use should be discussed with "management" and the "nurse involved."</p> <p>During interview on 5/25/22, at 11:07 a.m. social services designee (SSD) stated during her part into R1 and R2's 5/13/22 abuse report, she interviewed LPN-B via a telephone call in which LPN-B verbally explained she physically restrained R1 from hitting; however, LPN-B indicated she grabbed R1 around her waist and sat her on the chair. SSD denied she followed up with LPN-B once LPN-B returned to work for a physical explanation. She explained during her investigation she lacked an "alarming thought" about the maneuver; however, after the maneuver was physically explained to her by the surveyor, she acknowledged concern "because she was not able to release herself from that position, even if a matter of five seconds ...We definitely need to do some behavioral intervention education on this not being your initial response." The SSD denied R1's behaviors and interventions were comprehensively assessed or analyzed after the 5/13/22 resident to resident incident.</p> <p>When interviewed on 5/25/22, at 12:41 p.m. the</p> | 2 520                                                                                    |                                                                                                                          |  |                                                                    |



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| 2 520                                                            | <p>Continued From page 7</p> <p>DON stated an emergency restraint may be necessary "if a resident is swinging at someone's face" or "if they continue to try to go through you to get to another resident." The DON explained if an emergency restraint was required, a nurse may "not necessarily" need to document all actions taken prior and after the event "unless you had to do a bear hug hold like children who need to calm down. We do not do that here however." Updating the doctor would take "something drastic," such as, "you had to take someone to the ground." The DON explained based on LPN-B's verbal explanation of the manual hold during the initial facility investigation that LPN-B only placed her arms around R1's mid-section and assisted her back into the wheelchair. She denied LPN-B demonstrated the manual hold at that time. After the technique used by LPN-B on R1 was physically explained to the DON, the DON acknowledged the manual hold was considered a restraint "for a short period of time, probably." Further, she stated, based on the new understanding, she expected R1's chart to indicate exactly what the staff's actions were pre and post the manual hold, that R1's doctor was updated "right after the progress note" was written, R1 and her range of motion were assessed for any signs of injury, and R1's representative was notified about the incident and interventions required. The DON denied R1's behaviors and interventions were comprehensively assessed or analyzed after the 5/13/22 resident to resident incident.</p> <p>A policy Resident Physical Restraint, dated 3/29/22, identified a physical restraint was any manual method attached or adjacent to the resident that the resident could not easily remove and that restricted freedom of movement or normal access to their body. The policy directed</p> | 2 520                                                                                    |                                                                                                                          |  |                                                                    |



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| 2 520                                                            | <p>Continued From page 8</p> <p>staff to consider alternatives to restraints "before applying any kind of physical restraint," in which the alternatives and their responses "need to be documented." Examples of alternative interventions was provided. In addition, the policy directed staff to obtain a restraint order, along with representative notification.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/revise and implement policies and procedures related to emergency use of a restraint and the requirement a restraint order must be obtained which specifies the duration and circumstances under which the restraint was used and educate staff on these requirements. Additionally, the physician and resident representative must be immediately notified of the use of an emergency restraint. The quality assessment and assurance committee could perform random audits to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty One (21) days</p> | 2 520                                                                                    |                                                                                                                          |  |                                                                    |