DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 7, 2021

Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: November 18, 2020

Dear Administrator:

On December 11, 2020, we informed you of imposed enforcement remedies.

On December 31, 2020, the Minnesota Department(s) of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious remaining deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F0610 -- S/S: D -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation

In addition, at the time of this survey/revisit, we identified the following deficiency(ies):

F0609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 10, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 10, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 10, 2021.

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

As we notified you in our letter of December 11, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 10, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded

by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
St. Cloud B District Office
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
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 18, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

formal notification of that determination.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically Submitted
December 11, 2020

Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: November 18, 2020

Dear Administrator:

On November 18, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On November 18, 2020, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 10, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 10, 2021 (42 CFR 488.417 (a)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 10, 2021, (42 CFR 488.417 (a)).

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

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Talahi Nursing And Rehab Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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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.
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DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
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
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 their respective deficiencies (if any) is acceptable.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 18, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

EQUIPMENT/ENVIRONMENT

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.
- The director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time.

TRAINING/EDUCATION:

- The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training.

Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

- CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic_in_HCF_03.pdf
- MDH COVID-19 Toolkit. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

HAND HYGIENE

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review hand hygiene policies and procedures to ensure they meet CDC guidance, and revise as needed.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions and adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be incorporated into staff training.
- The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competency
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

  https://www.health.state.mn.us/people/handhygiene/ (MDH)
  Hand Hygiene (MDH) https://www.health.state.mn.us/people/handhygiene/index.html
  Hand Hygiene for Health Professionals (MDH)

https://www.health.state.mn.us/people/handhygiene/index.html
Cleaning Hands with Hand Sanitizer (MDH)
https://www.health.state.mn.us/people/handhygiene/clean/index.html
CDC: Guideline for Hand Hygiene in Health-Care Settings (CDC)
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm
WHO Guidelines on Hand Hygiene in Health Care (WHO)
https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf;jsessionid=A770590E49844880F6F3E1D8F22F0841?sequence=1
Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities (WHO)
https://www.who.int/gpsc/5may/hh_guide.pdf

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

SOCIAL DISTANCING CONCERNS

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Develop and implement procedures and policies to provide for, and enforce social distancing among residents/staff.
- Develop and implement procedures and policies to provide for social distancing during dining and/or activities.
- Assess each individual resident's ability to understand or willingness to comply with social distancing and care plan interventions to promote compliance.
- Develop and implement procedures to educate and remind residents to practice social distancing.
- Follow current CDC and MDH guidance on communal dining. (i.e. clothe masks/6 feet apart)
- Follow current CDC and MDH guidance on communal activities. (i.e. clothe masks/6 feet apart)

TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist, the Director of Nursing, all staff in the facility whether it be dietary, housekeeping staff, or activity staff. The training must cover the importance of social distancing of residents/staff/discontinuation of communal dining and activities. Online infection prevention training courses may be utilized. The Center for Disease Control (CDC) has specific COVID-19 training videos which cover social distancing and discontinuation of communal dining/activities.
https://www.cdc.gov/coronavirus/2019-ncov/communication/videos.html?Sort=Date%3A%3Adesc&Search=nursing%20home

Additional information may be used from the MDH COVID-19 Toolkit :
(https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)

- Include documentation of the training completed with a timeline for completion.
- Include documentation of the training completed with a timeline for completion

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
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https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
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Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will conduct rounds throughout the facility on each shift to ensure social distancing is being maintained by all staff and residents during various times of day and during various activities. The rounds will be conducted every day for four weeks, or until 100% compliance is obtained. Then the audits/monitoring may be decreased in frequency.

The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	R-C 12/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments No deficiencies were issued pertaining to the Centers for Medicare and Medicaid (CMS) Appendix Z Emergency Preparedness requirement(s) during the COVID-19 Focused Infection Control survey, exited on 11/18/20.	{E 000}		
{F 000}	INITIAL COMMENTS On 12/31/20, an onsite post certification revisit (PCR) was completed to follow up on Federal deficiencies issued related to an abbreviated complaint survey exited on 11/18/20. Talahi Nursing and Rehab Center was found not in compliance with 42 CFR Part 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaint(s) were found to be corrected: H5438095C; however, unrelated non-compliance with identified and cited as part of the PCR investigation at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable ePOC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		1/10/21

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

Electronically Signed | 01/07/2021

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F 609	Continued From page 1 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a voiced allegation of potential sexual abuse was reported to the administrator and State agency (SA) in a timely manner for 1 of 4 residents (R2) whose allegations were reviewed. Findings include: R2's quarterly Minimum Data Set (MDS), dated 11/22/20, identified R2 had moderate cognitive	F 609	• Allegation made by R2 has been reported to OHFC on 12/31/2020. Care plan reviewed/updated to include history of making this specific allegation. • Other known allegations of abuse have been reported timely • Resident protection plan policy reviewed • Nursing home staff to be educated on importance of reporting and investigating all allegations of abuse to Administrator	

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F 609	Continued From page 2 impairment and demonstrated no delusional behaviors or hallucinations. Further, the MDS identified R2 consumed daily antipsychotic medication and required extensive assistance to complete his activities of daily living (ADLs). On 12/31/20, at 1:17 p.m. R2 was interviewed. R2 expressed he had lived at the nursing home for "almost nine months" and admitted he was there due to mental health concerns. R2 reported he felt the staff treated him well; however, he then added, "But I got raped two times here." R2 explained he was raped by two male persons and provided their first and last names to the surveyor, voicing this rape happened while they were away from the nursing home and at a "vocational school." R2 voiced he reported the incident to "two social workers in this building" and they were "looking into it." Further, R2 stated he did not feel safe at the nursing home as a result of being raped. R2's progress note(s), dated 8/21/19 to 12/31/20, were reviewed. They lacked evidence of recorded episodes from 8/1/19 to 8/28/20, which described or outlined R2 as reporting being raped or potentially sexually assaulted. However, from 8/28/20 to 12/31/20, the following note(s) were recorded: On 8/29/20, R2 was recorded as frequently talking about friend (F)-A and voiced, " ... [F-A] and someone names [sic] [redacted] raped him and how it hurt really badly and we need to confront him and do something about it." R2 was provided as-needed pain medication, however, continued to discuss the "rape issue" afterwards. The note lacked any dictation indicating the administrator had been updated on the allegation.	F 609	and State Agency in timely manner, regardless of perceived accuracy of the allegation. • Audits for staff knowledge of reporting and investigating abuse to be completed 3 x week for four weeks, monthly for two months, and on-going as needed based on reviewed audit results. • Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation • NHA/Designee is responsible for ensuring compliance • Corrective Date of Compliance: 1/10/2021	

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On 8/31/20, R2 was recorded as yelling out throughout the shift including, "Bring me to the police station! I was raped 3 times!" The staff provided reassurance and one-to-one conversation which was listed as " ... mildly and temporarily effective."

On 9/1/20, the social worker completed a note which outlined she had spoken with R2 on his recent statements of being raped. R2 reported feeling safe in the nursing home and did not have concerns with his caregivers. The note concluded, "Resident has not left the building recently and has not had any visitors for several months. He has an appointment scheduled with his psychiatrist on 9/3/20."

On 9/2/20, R2 was recorded as being awake most of the night and putting his legs out of bed because " ... someone was coming." R2 shouted loudly and voiced " ... three guys knocked him down and raped him and then laughed ..." R2 voiced he knew these guys, named them and that he had reported it to the police department. The note continued, "He [R2] asked if the police were here yet."

On 9/3/20, R2 was seen by his psychiatrist which provided orders for medication adjustment.

On 9/9/20, R2 voiced per "State" to complain about being raped. The note outlined, "Resident stating we need to catch them."

On 9/10/20, R2's psychiatrist was consulted regarding R2's recent allegations of being raped which R2's psychiatrist voiced R2 had a history of serious delusions and fixed false beliefs. Further,

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R2 was conversed with immediately following where R2 believed he was in the local hospital and had been raped in his lifetime. R2 voiced not feeling safe at the nursing home and the nurses did not " ... understand the supernatural" and his friends had " ... backed him into a corner and laughed and they are OK it was 8 months ago." R2 believed it was a ghost hurting people. R2's corresponding Chart Note, dated 9/10/20, identified the dictation from R2's psychiatrist which read, " ... Apparently [R2] has been making statements that he had been raped by male staff members. Apparently there are no male staff members at the facility. I told [the nursing home staff] that I have no recollection of any time in the past where [R2] had indicated any sexual abuse that had ever occurred. He's never implied it, suggested it or claimed it at any time in the many years that I have seen him." The note outlined R2 as being delusional, at times, and continued, "While I take any claims of sexual abuse very seriously, with what [R2] is complaining of I would be highly suspicious if not totally so that this represents delusional thinking on his part, at least in terms of any kind of assault occurring toward him in recent times. Whether or not he had gone through abuse as a child is something that he has never brought up in the 25 plus years that I have known him."

There were no recorded progress note(s) from 9/11/20 to 12/17/20, which R2 alleged being sexually assaulted or raped.

On 12/18/20, R2 had a telehealth visit with his primary medical physician where he reported " ... that he had been raped twice by [F-A] and [F-D] this week sometime." The person completing the note identified R2 felt safe at the nursing home,

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and reported the concern to the facility' social worker (LSW)-A. A corresponding note, completed by LSW-A on 12/18/20, identified LSW-A visited with R2 about the allegation of rape. R2 reported the incident happened when they were living together "six months ago." The note continued, "[LSW-A] confirmed that this did not happen recently and resident has been at facility for two years, and was not living with friends like he reported." R2 was listed as having a history of making delusional statements.

On 12/21/20, R2 again voiced to the nursing staff about " ... being raped by '[F-C] and [F-A]." The nurse reassured R2 of his safety and discussed with R2 regarding the wound on his bottom may be causing him to attribute the pain in his bottom to being raped.

On 12/22/20, R2's psychiatrist provided new orders for R2's prescribed antipsychotic medication. A subsequent note, dated 12/22/20, identified LSW-A and the nurse manager met with R2 as he had voiced more statements of being raped by F-A and F-C. R2 reported these person(s) voiced they were "coming for him" and explained he believed he was currently in the Sherburne County building and the nurse was "chasing the guys down that raped him outside." R2 identified one of these persons as F-C and LSW-A voiced the facility had not been accepting visitors "for a long time," so he was safe and reviewed the wound on his bottom maybe causing pain; however, R2 then became offended and voiced, "That's not true!" Further, an additional note, dated 12/22/20, identified R2's psychiatrist was updated on the verbalized allegations of rape. The note identified the psychiatrist responded, "You have done

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everything you can to manage this, it is a delusional disorder and these are not new delusions. this [sic] needs to be managed with medication at this point." R2's antipsychotic medication was increased; and the psychiatrist voiced they would follow up in two weeks.

On 12/23/20, R2 voiced to staff F-C "was here last night" and he could hear him through the intercom. R2 denied physically seeing F-C in the building, but reiterated he could hear him.

On 12/28/20, R2 voiced a concern about being raped stating he "saw them" last night and they would not let him contact the police department. R2 again voiced two men had raped him and it hurt "really bad." R2 voiced the incident happened " ... awhile ago, like June or July." R2 reported hearing the mens' voices "all the time" and named F-A and F-C. R2 did not appear distressed by the conversation and voiced, " ... all I want is an apology from them."

R2's care plan, dated 11/29/20, identified R2 as being at risk for "impaired function" in his support system and, as a result, R2's friends (F)-A and F-B help to offer medical advice and advise him in such decision making. R2 was recorded as consuming psychotropic medications for schizophrenia and having a history of delusions and auditory hallucinations which cause agitation. The care plan continued and outlined two separate sections, both last initiated and/or revised on 9/1/20, which dictated R2 had a history of experiencing events which were " ... physically and emotionally harmful" including sexual abuse described as, " ... which I will sometimes believe happened recently." R2 was listed as having psychosocial well-being problem(s) due to his

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delusions and hallucinations which, at times, caused R2 to believe others were present in his room who he would voice are having sex. Further, the care plan outlined R2, "Talks about being raped due to history of sexual violence, often believing it happened recently," and outlined several interventions to to help R2 cope with these problems including allowing R2 time to answer questions and verbalize feelings, consulting with social services or psychiatric services, and providing opportunities for R2 and family to participate in care. Further, a provided Care Plan History report, printed 12/31/20, verified the care plan lacked any information on R2 alleging episodes of being raped until 9/1/20, when it was added.

However, R2's medical record was reviewed and lacked evidence the multiple allegations of potential sexual assault had been reported to the administrator when they first happened (on 8/29/20) nor to the state agency (SA). Further, a provided untitled listing, dated 3/11/20 to 12/5/20, identified all of the facility's reported allegations of abuse and/or neglect. R2's repeated allegations of rape were not listed.

When interviewed on 12/31/20, at 1:22 p.m. nursing assistant (NA)-A voiced R2 had been talking about being raped for "six months now" to her recall. NA-A stated she was unaware R2 had identified specific names of persons who potentially raped him adding, "[He's] never mentioned two guys to me though." At 1:23 p.m. licensed practical nurse (LPN)-A joined the interview and explained someone had told her prior that R2 was sexually assaulted when he was a child and voiced R2 was a paranoid schizophrenic and would often report being able

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to hear voices through intercoms and aloud. R2 would also, at times, voice these persons would "come through the window."

On 12/31/20, at 1:48 p.m. registered nurse manager (RN)-A was interviewed. RN-A explained she had recently assumed R2's care and described him as "very confused" who often reported people were visiting him when "we're not allowing any visitors at all into the building." RN-A voiced she was aware of his repeated allegations of being raped by two men as the management had "brought it up" during the daily stand-up meetings. RN-A voiced she understood these allegations had already been reported and investigated "when they fist happened" to determine no actual abuse had or was still occurring to R2. As a result, the second allegations (starting on 12/18/20) were not reported or investigated as they had already care planned the allegations as behavioral. However, RN-A then explained one of the named persons R2 was alleging as potentially raping him was a "person of contact" for him who was someone "who came to visit" R2 prior to the COVID restrictions being placed in March 2020. At 2:22 p.m. LSW-A and RN-B joined the interviewed. They explained R2 admitted to the nursing home in December 2018, and had been "in and out" of the hospital several times since then. R2 required total assistance with his cares and his cognition was "not very good" given his history of delusions and hallucinations. They voiced R2 had voiced the allegations in September 2020, and the allegations had been "talked about pretty in-depth" by themselves and the management team. However, the voiced allegations were not reported to the SA as they were under the impression it had already been addressed and

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F 609	Continued From page 9 determined to be behavioral. At this time, an online call was placed to the Minnesota Department of Health (MDH) Federal triage specialist with RN-A and LSW-A present. The specialist reviewed the Federal database for submitted allegations and verified there was no submitted reporting to the SA for R2 regarding any allegation(s) of sexual assault and/or rape. RN-A, RN-B and LSW-A reiterated it was not reported as they believed it had already been done and care planned accordingly. At 3:00 p.m. the administrator joined the interview and explained she first learned of the allegations in the past couple weeks as the facility started completing frequent behavior meetings for a prior survey's plan of correction. The administrator acknowledged the lack of documentation supporting the allegation(s) being reported to her or the SA and voiced, to her knowledge, the repeated allegations were not filed or treated as a potential vulnerable adult (VA) issue given R2's history of accusations as they felt it "was not reportable" given his history of such. A provided Vulnerable Adult Abuse and Neglect Prevention policy, dated 11/17/20, identified the facility would follow Federal guidelines dedicated to the prevention of abuse. The policy outlined any nursing home employee who becomes aware of such allegations should immediately report them to the administrator or designee; who would then report them to the SA per requirements. Further, the policy outlined, "The facility must report to the [SA] immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse ..."	F 609		
{F 610} SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	{F 610}		1/10/21

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{F 610}	Continued From page 10 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure voiced allegations of potential sexual abuse were thoroughly investigated to rule out abuse and determine if protection plan(s) were needed to ensure 1 of 4 residents (R2) remained free of abuse while residing at the nursing home. Findings include: R2's quarterly Minimum Data Set (MDS), dated 11/22/20, identified R2 had moderate cognitive impairment and demonstrated no delusional behaviors or hallucinations. Further, the MDS identified R2 consumed daily antipsychotic medication and required extensive assistance to complete his activities of daily living (ADLs).	{F 610}	• Allegation made by R2 has been reported to State agency on 12/31/2020, has been investigated, and has been determined to not be substantiated. Resident sexual vulnerability assessment updated. Care plan reviewed/updated to include history of making specific allegation. • Other resident allegations of abuse have been investigated at this time • Resident protection plan policy reviewed • Nursing home staff to be educated on importance of reporting and investigating all allegations of abuse to Administrator and State Agency in timely manner, regardless of perceived accuracy of the allegation. All allegations of abuse will be	

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{F 610}	Continued From page 11 On 12/31/20, at 1:17 p.m. R2 was interviewed. R2 expressed he had lived at the nursing home for "almost nine months" and admitted there due to mental health concerns. R2 reported he felt the staff treated him well; however, he then added, "But I got raped two times here." R2 explained he was raped by two male persons and provided their first and last names to the surveyor, voicing this rape happened while they were away from the nursing home and at a "vocational school." R2 voiced he reported the incident to "two social workers in this building" and they were "looking into it." Further, R2 stated he did not feel safe at the nursing home as a result of being raped. R2's progress note(s), dated 8/21/19 to 12/31/20, were reviewed. The following was recorded: On 12/12/19, R2 was recorded as having paranoid thoughts and hallucinations "thinking [friend; F-A] 'is going to assassinate me." The staff provided a one-to-one and listed is partially effective in re-assuring him. On 6/28/20, R2 had called the police department and voiced to them a friend (unnamed) was trying to kill him. The police contacted the nursing home and the charge nurse updated them on R2's history of delusional thoughts and reassured them R2 was safe. On 7/6/20, R2 returned from an appointment and voiced, "A threat to my [R2] life." R2 reported F-A and F-C as being in the room "next door" about how to kill R2. The note outlined, "[F-A] is a friend of resident's who used to visit the facility when he first admitted. Staff do not recall seeing him in the building for about a year."	{F 610}	investigated thoroughly by NHA/designee(s), and plan of care updated to ensure resident safety. • Audits for staff knowledge of reporting and investigating abuse to be completed 3 x week for four weeks, monthly for two months, and on-going as needed based on reviewed audit results. • Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation • NHA/Designee is responsible for ensuring compliance	

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There were no recorded progress note(s) from 8/1/19 to 8/28/20, which described or outlined R2 as reporting being raped or potentially sexually assaulted.

On 8/29/20, R2 was recorded as frequently talking about F-A and voiced, " ... [F-A] and someone names [sic] [redacted] raped him and how it hurt really badly and we need to confront him and do something about it." R2 was provided as-needed pain medication, however, continued to discuss the "rape issue" afterwards. The note lacked any dictation on if the administrator had been updated on the allegation.

On 8/31/20, R2 was recorded as yelling out throughout the shift including, "Bring me to the police station! I was raped 3 times!" The staff provided reassurance and one-to-one conversation which was listed as " ... mildly and temporarily effective."

On 9/1/20, the social worker completed a note which outlined she had spoken with R2 on his recent statements of being raped. R2 reported feeling safe in the nursing home and did not have concerns with his caregivers. The note concluded, "Resident has not left the building recently and has not had any visitors for several months. He has an appointment scheduled with his psychiatrist on 9/3[/20]."

On 9/2/20, R2 was recorded as being awake most of the night and putting his legs out of bed because " ... someone was coming." R2 shouted loudly and voiced " ... three guys knocked him down and raped him and then laughed ..." R2 voiced he knew these guys, named them and that he had reported it to the police department. The

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note continued, "He [R2] asked if the police were here yet."

On 9/3/20, R2 was seen by his psychiatrist which provided orders for medication adjustment. A corresponding

On 9/9/20, R2 voiced per "State" to complain about being raped. The note outlined, "Resident stating we need to catch them."

On 9/10/20, R2's psychiatrist was consulted regarding R2's recent allegations of being raped which R2's psychiatrist voiced R2 had a history of serious delusions and fixed false beliefs. Further, R2 was conversed with immediately following where R2 believed he was in the local hospital and had been raped in his lifetime. R2 voiced not feeling safe at the nursing home and the nurses did not " ... understand the supernatural" and his friends had " ... backed him into a corner and laughed and they are OK it was 8 months ago." R2 believed it was a ghost hurting people.

R2's corresponding Chart Note, dated 9/10/20, identified the dictation from R2's psychiatrist which read, " ... Apparently [R2] has been making statements that he had been raped by male staff members. Apparently there are no male staff members at the facility. I told [the nursing home staff] that I have no recollection of any time in the past where [R2] had indicated any sexual abuse that had ever occurred. He's never implied it, suggested it or claimed it at any time in the many years that I have seen him." The note outlined R2 as being delusional, at times, and continued, "While I take any claims of sexual abuse very seriously, with what [R2] is complaining of I would be highly suspicious if not totally so that this

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represents delusional thinking on his part, at least in terms of any kind of assault occurring toward him in recent times. Whether or not he had gone through abuse as a child is something that he has never brought up in the 25 plus years that I have known him."

There were no recorded progress note(s) from 9/11/20 to 12/17/20, which R2 alleged being sexually assaulted or raped.

On 12/18/20, R2 had a telehealth visit with his primary medical physician where he reported " ... that he had been raped twice by [F-A] and [F-D] this week sometime." The person completing the note identified R2 felt safe at the nursing home, and reported the concern to the facility' social worker (LSW)-A. A corresponding note, completed by LSW-A on 12/18/20, identified LSW-A visited with R2 about the allegation of rape. R2 reported the incident happened when they were living together "six months ago." The note continued, "[LSW-A] confirmed that this did not happen recently and resident has been at facility for two years, and was not living with friends like he reported." R2 was listed as having a history of making delusional statements.

On 12/21/20, R2 again voiced to the nursing staff about " ... being raped by '[F-C] and [F-A]." The nurse reassured R2 of his safety and discussed with R2 regarding the wound on his bottom may be causing him to attribute the pain in his bottom to being raped.

On 12/22/20, R2's psychiatrist provided new orders for R2's prescribed antipsychotic medication. A subsequent note, dated 12/22/20, identified LSW-A and the nurse manager met

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with R2 as he had voiced more statements of being raped by F-A and F-C. R2 reported these person(s) voiced they were "coming for him" and explained he believed he was currently in the Sherburne County building and the nurse was "chasing the guys down that raped him outside." R2 identified one of these persons as F-C and LSW-A voiced the facility had not been accepting visitors "for a long time," so he was safe and reviewed the wound on his bottom maybe causing pain; however, R2 then became offended and voiced, "That's not true!" Further, an additional note, dated 12/22/20, identified R2's psychiatrist was updated on the verbalized allegations of rape. The note identified the psychiatrist responded, "You have done everything you can to manage this, it is a delusional disorder and these are not new delusions. this [sic] needs to be managed with medication at this point." R2's antipsychotic medication was increased; and the psychiatrist voiced they would follow up in two weeks.

On 12/23/20, R2 voiced to staff F-C "was here last night" and he could hear him through the intercom. R2 denied physically seeing F-C in the building, but reiterated he could hear him.

On 12/28/20, R2 voiced a concern about being raped stating he "saw them" last night and they would not let him contact the police department. R2 again voiced two men had raped him and it hurt "really bad." R2 voiced the incident happened " ... awhile ago, like June or July." R2 reported hearing the mens' voices "all the time" and named F-A and F-C. R2 did not appear distressed by the conversation and voiced, " ... all I want is an apology from them."

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{F 610}	Continued From page 16 R2's care plan, dated 11/29/20, identified R2 as being at risk for "impaired function" in his support system and, as a result, R2's friends (F)-A and F-B help to offer medical advice and advise him in such decision making. R2 was recorded as consuming psychotropic medications for schizophrenia and having a history of delusions and auditory hallucinations which cause agitation. The care plan continued and outlined two separate sections, both last initiated and/or revised on 9/1/20, which dictated R2 had a history of experiencing events which were " ... physically and emotionally harmful" including sexual abuse described as, " ... which I will sometimes believe happened recently." R2 was listed as having psychosocial well-being problem(s) due to his delusions and hallucinations which, at times, caused R2 to believe others were present in his room who he would voice are having sex. Further, the care plan outlined R2, "Talks about being raped due to history of sexual violence, often believing it happened recently," and outlined several interventions to to help R2 cope with these problems including allowing R2 time to answer questions and verbalize feelings, consulting with social services or psychiatric services, and providing opportunities for R2 and family to participate in care. Further, a provided Care Plan History report, printed 12/31/20, verified the care plan lacked any information on R2 alleging episodes of being raped until 9/1/20, when it was added. However, R2's medical record was reviewed and lacked evidence the multiple allegations of potential sexual assault had been comprehensively investigated to determine what, if any, of the voiced allegations were credible and if a subsequent protection plan to ensure R2	{F 610}		

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remained safe needed to be implemented despite R2 accusing someone whom was listed on his care plan as a friend who helps him make decisions. Further, there was no evidence provided during the onsite survey which outlined a state agency (SA) 'Five-Day' report had been completed and submitted demonstrating such investigation had been completed since 8/29/20, when R2 first made an allegation of rape while living at the nursing home.

When interviewed on 12/31/20, at 1:22 p.m. nursing assistant (NA)-A voiced R2 had been talking about being raped for "six months now" to her recall. NA-A stated she was unaware R2 had identified specific names of persons who potentially raped him adding, "[He's] never mentioned two guys to me though." At 1:23 p.m. licensed practical nurse (LPN)-A joined the interview. She explained someone had told her prior that R2 was sexually assaulted when he was a child and voiced R2 was a paranoid schizophrenic and would often report being able to hear voices through intercoms and aloud. R2 would also, at times, voice these persons would "come through the window." LPN-A verified R2 had not had any recent visitors, including F-A or F-C, due to the COVID-19 pandemic restrictions.

On 12/31/20, at 1:48 p.m. registered nurse manager (RN)-A was interviewed. RN-A explained she had recently assumed R2's care and described him as "very confused" who often reported people were visiting him when "we're not allowing any visitors at all into the building." RN-A voiced she was aware of his repeated allegations of being raped by two men as the management had "brought it up" during the daily stand-up meetings. RN-A voiced she understood these

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allegations had already been reported and investigated "when they fist happened" to determine no actual abuse had or was still occurring to R2. As a result, the second allegations (starting on 12/18/20) were not reported or investigated as they had already care planned the allegations as behavioral. However, RN-A then explained one of the named persons R2 was alleging as potentially raping him was a "person of contact" for him who was someone "who came to visit" R2 prior to the COVID restrictions being placed in March 2020. At 2:22 p.m. LSW-A and RN-B joined the interviewed. They explained R2 admitted to the nursing home in December 2018, and had been "in and out" of the hospital several times since then. R2 required total assistance with his cares and his cognition was "not very good" given his history of delusions and hallucinations. They voiced R2 had voiced the allegations in September 2020, and the allegations had been "talked about pretty in-depth" by themselves and the management team. However, the voiced allegations were then just care planned and there was no documented evidence they could provide demonstrating the repeated allegations had been comprehensively investigated as an allegation of sexual abuse, despite R2 alleging F-A as a potential alleged perpetrator (AP) who had visited him at the nursing home in the past. They voiced they had never investigated the allegation(s) as they were under the impression it had already been "addressed" prior to these recent allegations. At 3:00 p.m. the administrator joined the interview and explained she first learned of the allegations in the past couple weeks as the facility started completing frequent behavior meetings for a prior survey' plan of correction. The administrator acknowledged the lack of documentation

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{F 610}	Continued From page 19 supporting a comprehensive investigation into the allegations and voiced, to her knowledge, the repeated allegations were not filed or treated as a potential vulnerable adult (VA) issue given R2's history of accusations as they felt it "was not reportable" given his history of such. The administrator voiced she felt there had likely been no actual abuse to R2, however, acknowledged someone with a history of false accusations and delusional beliefs is greatly susceptible to abuse given a risk staff would potentially not believe potential credible allegations. A provided Vulnerable Adult Abuse and Neglect Prevention policy, dated 11/17/20, identified the facility would follow Federal guidelines dedicated to the prevention of abuse and timely, thorough investigation of such allegations. The policy outlined any allegations were to be immediately reported to the administrator, and then an investigation would be completed which included completing interviews from all parties involved, documenting resident' behavior and observations made during the investigation, and, following up with the resident' physician. The policy outlined, "The investigation and written findings are completed and reviewed ... [and] ... A plan for further action is determined with input from appropriate personnel."	{F 610}		

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	245438	A. BUILDING _____ B. WING _____	C 11/18/2020

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TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

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E 000	Initial Comments On 11/13/20 to 11/18/20, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health (MDH) to determine compliance with Emergency Preparedness regulations §483.73(b)(6). Talahi Nursing and Rehab was found in compliance with the requirement(s). Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/13/20 to 11/18/20, an abbreviated survey was completed at your facility to conduct complaint investigation(s). Talahi Nursing and Rehab was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5438095C with a deficiency cited at F600. The survey resulted in findings of immediate jeopardy (IJ) and substandard quality of care. An IJ at F600 began on 10/19/20, when a behavioral resident's (R2) antipsychotic medication was abruptly stopped and the resulted escalating behaviors, including newly recorded sexual behaviors, were not assessed and interventions developed to ensure safety of himself and others. This ultimately contributed to R2 sexually assaulting another dependent, non-verbal female resident (R1) who resided at the nursing home.	F 000		

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

Electronically Signed | 12/18/2020

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F 000	Continued From page 1 The regional director of operations (RDO) and director of nursing (DON) were notified of the IJ on 11/17/20, at 3:39 p.m. The IJ was removed on 11/18/20; however, non-compliance remained at an isolated scope of actual harm (Level G). Further, an extended survey was conducted on 11/18/20. In addition, a COVID-Focused Infection Control survey was conducted to determine compliance with §483.80 Infection Control. The facility was found to not be in compliance with the requirement. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		12/23/20

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F 580	Continued From page 2 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	" R2 was discharged from the facility on	

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F 580	Continued From page 3 facility failed to ensure the appointed guardian was notified in a timely manner of refused treatments for 1 of 1 residents (R2) reviewed who refused required laboratory monitoring and subsequently missed multiple doses of prescribed antipsychotic medication. Findings include: A submitted state agency (SA) Incident Report, dated 11/6/20, identified a facility' reported allegation of sexual abuse involving R2 and another female resident. The report outlined R2 had been found in R1's room " ... having sexual intercourse." The report outlined the police were contacted and removed R2 from the facility. R2's quarterly Minimum Data Set (MDS), dated 9/29/20, identified R2 had schizophrenia along with moderate cognitive impairment. Further, R2 demonstrated no hallucinations, delusions or rejection of care(s) behaviors. Further, R2's Admission Record, printed 11/18/20, identified an appointed guardian (G)-A as his responsible party. On 11/13/20, at 12:22 p.m. G-A was interviewed. G-A explained she was aware of an incident which had happened involving R2 sexually assaulting another resident while residing at the nursing home, and expressed frustration as R2's mental state had been "stable until he went off his meds." G-A voiced she had not been notified until weeks afterwards, on 11/2/20, that R2 had refused the laboratory monitoring and subsequently had not been provided his ordered antipsychotic medication. G-A voiced frustration at the lack of timely notification and expressed the facility had held a care conference with her	F 580	11/6/2020. " Residents who refuse their psychotropic medications, treatments, or labs have the potential to be affected if their appointed guardians or legal decision makers are not notified of the refusals. Residents with psychotropic medications will be monitored daily on business days for any refusals of psychotropic medications, treatments, or labs. If pattern of refusals occurs, the appointed guardians or legal decision makers will be notified of the refusal. " Licensed nursing staff/TMA educated on the importance of identifying refusals and notifying appointed guardians or legal decision makers of the refusal. " Weekly audits for 2 months for residents with psychotropic medications for a pattern of refusals of the psychotropic medications, treatments or labs will be completed to validate that the appointed guardian or legal decision maker has been notified of the refusal. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation " DON/Designee is responsible	

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F 580	Continued From page 4	F 580		

towards the end of October, and still even then "not one word" of the refusal and held medication was mentioned.

R2's progress note, dated 10/19/20, identified the pharmacy came to deliver R2's antipsychotic medication and draw routine laboratory work. R2 refused and threw his coffee at the employee. The note outlined, "Pharmacy unable to delivery [sic] medication since resident refused lab draw." The note identified registered nurse (RN)-A was updated.

R2's Medication Administration Record (MAR), dated 10/2020 to 11/2020, identified R2's physician ordered medications and their subsequent administration record(s). An order was listed for clozapine (an antipsychotic medication) 500 milligrams (mg) everyday; which had a listed start date of 6/25/20. The medication was record as being given and consumed by R2 until 10/20/20. From 10/21/20 to 11/5/20, the MAR identified nearly all subsequent doses of the medication were not given with numerous entries of, "18," which was identified via legend as, "Med not available from pharmacy."

Further, R2's Care Plan Conference Summary, dated 10/23/20, identified a quarterly care conference had been held with G-A in attendance along with RN-A and licensed social worker (LSW)-A. A section labeled, "Psychotropic Med Review," was listed which outlined R2's medications had been reviewed and informed consents were on file. The completed form lacked any evidence R2's refused laboratory monitoring, and the subsequent holding of his ordered antipsychotic medication, was discussed or reviewed.

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R2's medical record, including recorded progress notes, were reviewed and lacked evidence R2's appointed guardian had been immediately notified of the refused laboratory monitoring and his antipsychotic medication being held as a result.

On 11/13/20, at 1:07 p.m. RN-A and LSW-A were interviewed. They verified R2 had refused his laboratory draw on 10/19/20, and his clozapine was held as a result because the pharmacy would not leave the medication without the laboratory draw being completed to ensure R2 was safe to continue taking the medication. They reviewed R2's medical record and acknowledged it lacked evidence R2's guardian had been updated on those events, and voiced the cart nurses should have ensured G-A was updated on 10/19/20. LSW-A verified a care conference was held for R2 on 10/23/20, and the laboratory draw and medication hold was not discussed as she "wasn't fully aware of all of this [those events]" until R2 was hospitalized on 11/3/20. RN-A expressed R2's guardian should have been updated "right away."

When interviewed on 11/17/20, at 11:32 a.m. the director of nursing (DON) stated she was unsure of the exact date when R2's guardian had been formally notified of the refused laboratory draw and subsequent antipsychotic medication being held; however, recalled it being the week of 10/26/20 at some time (at least six days later). The DON voiced her expectation would have been for R2's guardian to be updated the same day the laboratory draw was refused.

A provided Change in Condition policy, dated 12/19/18, identified a purpose of ensuring prompt

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F 580	Continued From page 6 notification of changes in the resident's physical, psychosocial and/or mental status to the physician and/or responsible party. The policy outlined several examples of issue(s) which required 'prompt notification' including, "A need to alter the resident's medical treatment significantly," and, "Refusal of treatment or medications (i.e. two (2) or more consecutive times)."	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R2) with escalating behaviors, including newly recorded sexual behaviors, was comprehensively assessed and interventions implemented to mitigate risk to others and prevent subsequent sexual assault of 1 of 1 residents (R1) reviewed whom was non-verbal and dependent on staff for their care. These findings resulted in an	F 600	" The facility completed vulnerability risk assessment on all residents, including resident R1. Care plans were updated and revised with identified areas of vulnerability and/or risk. " Facility immediately identified any residents with consistently missed or refused psychotropic medications and new/changing behaviors. No residents	12/23/20

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F 600	Continued From page 7 immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home. The IJ began on 10/19/20, when R2 refused routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded sexual behaviors, which the facility had knowledge of but failed to comprehensively assess and develop interventions to help manage and reduce the risk of injury or assault to others. This contributed to R2 subsequently entering R1's room and sexually assaulting her; and although R2 was removed from the nursing home, the facility had not reassessed R1's vulnerability to potential abuse from others despite being sexually assaulted. The regional director of operations for Minnesota (RDO) and director of nursing (DON) were notified of the IJ for R1 on 11/17/20, at 3:39 p.m. The IJ was removed on 11/18/20, at 4:36 p.m. when the facility successfully implemented a removal plan; however, non-compliance remained at an isolated scope with actual harm (Level G). Findings include: A submitted state agency (SA) Incident Report, dated 11/6/20, identified a facility's reported allegation of sexual abuse involving R1 and R2. The report outlined R2 had been found in R1's room " ... having sexual intercourse." The report outlined the police were contacted and removed R2 from the facility, and R1 was transported to the hospital for evaluation. Further, the report listed several witnesses to the allegation which included nursing assistant (NA)-A, NA-B, licensed	F 600	were identified. " Behavior management policy was reviewed and updated to include: o Notification of primary physician/NP, Mental health professional, and resident representative will be updated as applicable if resident consistently refuses psychotropic medication. " Vulnerable Adult Abuse and Neglect Prevention policy was reviewed in relation to the vulnerability risk assessment. " Like Residents: o House Audit was conducted to identify any residents that have consistently missed or refused psychotropic medications and are exhibiting new/changing behaviors. o Residents who would have consistently missed or refused psychotropic medications and have new/changing behaviors would be reviewed during morning meeting with IDT. Appropriate interventions and monitoring will be implemented based on review. o Residents identified as high vulnerability risk due to inability to physically and mentally defend oneself, will have care plans reviewed and updated as applicable based on review. " System Correction: o Licensed staff were educated on the appropriate procedure, including notification of provider and resident representative, for consistently missed/refused psychotropic medication. o Staff were provided education regarding identification and management of new/changing behaviors,	

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F 600	Continued From page 8 practical nurse (LPN)-A and registered nurse (RN)-B. R2's quarterly MDS, dated 9/29/20, identified R2 had schizophrenia (a disorder which affects a person's ability to think, feel, and behave clearly) and moderate cognitive impairment. Further, R2 demonstrated no hallucinations, delusions or rejection of care behaviors, and required only supervision with ambulation in the corridor and his room. R2's most recent Psychotropic Medication Review and Evaluation, dated 9/22/20, identified R2 had schizophrenia and received several psychotropic medications including loxapine (an antipsychotic), clonazepam (used to reduce anxiety), and clozapine (another antipsychotic medication). The form identified a primary target behavior which read, "Hearing voices," and this was listed as happening every two weeks. The assessment listed a radio-button style question which read, "Do these behaviors cause the resident to present a danger to themselves or others ... of interfere with the staff's ability to give care?" This was answered, "No." Further, the assessment identified R2's behaviors and management as, "Controlled." R2's care plan, dated 10/5/20, identified R2 had a communication deficit and directed staff to, "Anticipate and meet needs." R2 consumed antipsychotic medication and the care plan listed a goal of being free of psychotropic medication related complications with several interventions to help R2 meet this goal including, but not limited to, administering the medication(s) as ordered, consulting with the pharmacist and physician on potential dose reductions, and monitoring for	F 600	implementation of new interventions, and increased monitoring and providing increased supervision as needed. o Staff were re-educated on the policy and procedure for Vulnerable Adult Abuse and Neglect Prevention. This includes how to identify the signs and symptoms of possible abuse, especially amongst the most vulnerable population. These signs and symptoms of possible abuse can include unknown bruising, unexplained changes in resident condition, as well as mood and demeanor changes. o Residents who have consistently missed or refused psychotropic medications and have new/changing behaviors will be reviewed during morning meeting with IDT. " Monitoring: o Administrator or Designee is responsible to complete QA (Quality Assurance) tool on: ¿ Residents identified to be at high risk based on the vulnerability risk assessment will be reviewed to identify interventions noted on the plan of care are being followed to ensure the resident□s safety. Audit will be completed weekly X4 weeks, then monthly X 1 month. o Residents who are receiving psychotropic medications will be reviewed for missing/refused medications, changing behaviors, and appropriate interventions put in place in the care plan. Audit will be completed weekly X4 weeks, then monthly X 1 month.	

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adverse side effects including agitation and restlessness. Further, the care plan identified R2 was considered a vulnerable adult due to his cognitive impairments and outlined several interventions which included discussing behavioral issues with the interdisciplinary team (IDT), evaluating for possible causative factors if issues are identified, and, "Resident requires close observation." The care plan lacked further dictation on how R2 would be closely observed to ensure his or others safety.

R2's medical record was reviewed and identified the following:

On 8/18/20, a progress note identified R2's ordered loxapine was reduced to 25 milligrams (mg) due to an abnormal ECG (records the electrical signal from your heart to check for heart conditions). There were orders to follow-up with the psychiatric nurse practitioner (NP)-A in one month.

On 10/1/20, a progress note identified R2 had refused his bath despite re- approach. The note did not identify any other demonstrated behaviors by R2 despite refusing his bath.

On 10/15/20, a FOCUS progress note was recorded which listed, "Behaviors," as the reason for review. R2 was recorded as having schizophrenia and R2's loxapine reduction (from 8/18/20) was identified. R2 had moderate cognitive impairment and a section labeled, "Mood/Behavior," identified R2 as having anxiety and restlessness. However, the note lacked any further information on these listed behaviors, including how often the behaviors were happening, if at all, or specifics around any

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demonstrated episodes of them. Further, the note identified a section labeled, "Care plan interventions," which directed, "Notify MD [medical doctor] with any mood changes are observed, trauma informed approach observing and monitoring, provide opportunities for expression of feelings."

There were no further recorded behaviors demonstrated by R2 in the progress note(s) from 9/1/20 to 10/19/20.

On 10/19/20, a progress note identified the pharmacy came to deliver R2's antipsychotic medication and draw routine laboratory work. R2 refused and threw his coffee at the employee. The note outlined, "Pharmacy unable to delivery [sic] medication since resident refused lab draw." The note identified registered nurse (RN)-A was updated.

On 10/22/20 (three days later), a progress note identified R2 had refused the laboratory draw on 10/19/20, and it was ordered they continue to re-approach R2 and attempt to obtain the lab(s) so R2's clozapine prescription could be filled.

A corresponding Genevive (Physican Group) Progress Note, dated 10/22/20, identified R2's medical nurse practitioner (NP)-B was updated on R2's refusal to allow the laboratory draw on 10/19/20, so no medication was available for administration as a result. R2 was listed as consuming (receiving) 500 mg of clozapine everyday. The note outlined NP-B responded, "Please call and tell [nursing home] to keep trying with labs. His psychiatrist is the ordering provider I believe."

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On 10/23/20, a late-entry progress note was recorded which identified NP-B had been updated on R2's refusal to allow laboratory draw(s) for his clozapine. The note continued, "[NP-B] wanted Nystrom appointment made ASAP [as soon as possible]. Nystrom [psychiatry clinic] appointment made for 11/12/20."

On 10/31/20, a progress note identified R2 came and sat by the 'West Desk.' R2 was questioned if he needed anything by the staff, but then " ... began yelling at writer to shut up. After a few minutes a [NA] came down the hallway and he looked at her and yelled 'you fucking nigger' X3 [three times]." R2 was recorded as spending "a good portion" of the day outside of his room walking around, including standing by the front door and pushing buttons in attempt to open it. The note lacked any evidence of interventions attempted by the staff to calm or redirect R2 despite these behaviors.

On 11/1/20, a progress note identified R2 was recorded as being, " ... very agitated, restless and having hallucinations during shift ... [nurse] waved at him and resident flicked nurse off, said 'fuck you' ... drew his arm back as if acting he was going to punch nurse." The note continued, "This is very abnormal behavior for resident." The nurse sat down next to R2 and talked with him which was effective in calming him down. The note identified the laboratory had attempted to draw R2's lab(s) on the prior shift which is what caused resident to become upset." R2 was provided education on the importance of the lab draw, however, the note outlined R2 continued to be observed as restless but without physical aggression or agitation. The note continued, "[R2] approached nurse stating 'I am hearing voices.'

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Nurse asked what the voices were telling him and resident replied 'That no one likes me, everyone hates me, and that I should just die." The note identified the nurse provided comfort to R2 whom proceeded to hug the nurse and become upset and start crying. Genevive (physician service) was contacted due to R2's continued restlessness and an order for clonazepam 0.5 mg twice a day as-needed was provided for a three (3) day period " ... until cozapine issue was resolved." This was administered to R2 and the note recorded, " ... appeared to have effectiveness."

R2's corresponding Genevive Phone Encounter note, dated 10/31/20, identified the nursing home had contacted the service reporting R2 " ... is experiencing increased agitation, aggression and hallucinations ... patient was receiving Clozapine [sic], though a script has not been sent as they are waiting for lab work to be completed, though patient continues to refuse labs ... staff are concerned for his agitation." The note identified an order for clonazepam 0.5 mg twice a day as-needed for three days was provided along with, "Nursing staff are to follow-up with patient's PCP [primary care provider] this week regarding his agitation."

On 11/1/20, another progress note was recorded which identified R2 was " ... noted to be pacing around facility through out the morning. Per [night shift] report, resident was up all night pacing and did not sleep. Resident asking staff to purchase cigarettes for him. Yelling at staff 'I can smoke if I want! I'm over 18!' Emotional support and reassurance provided. Resident then approached staff member at front desk. Became upset with staff member when unable to get cigarettes and

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threw desk supplies across lobby." The note outlined education and encouragement was provided, however, R2 " ... Becomes more and more angry as staff re-approach." R2 was then provided time and space to express his feelings and " ... appeared to calm down but continues to refuse medications."

On 11/2/20, a progress note identified staff entered R2's room and R2 " ... had his pants off and was laying in bed. [R2] was masturbating." R2 proceeded to cover himself and the nurse provided R2 his oral pills when R2 then " ... put his right hand around the writers clavicle area then took his hand away and started to laugh." The note identified the nurse explained it was not appropriate to grab them in such a manner and left the room.

On 11/2/20, a subsequent progress note identified, "New behavior symptom noted. Behavior addressed with NP and guardian."

On 11/3/20, a progress note identified order(s) were received from NP-B to send R2 to the emergency room (ER). A subsequent note, dated 11/3/20, identified R2 had met with his guardian (G)-A and the nurse attempted to get the needed laboratory draw completed while she was present. The note recorded, " ... resident yelled 'Fuck you, you ain't taking any labs', then resident picked up an orange traffic cone and threw it at his guardian." NP-B was updated regarding the continued inability to draw the needed lab(s) and R2 " ... had been off his clozapine for almost two weeks, and that writer believed resident needed to be sent in to the hospital for further evaluation." R2 was sent to the hospital ER via ambulance.

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R2's corresponding Genevive Progress Note, dated 11/3/20, identified NP-B was contacted as R2 had gone without his ordered clozapine for two weeks as he was refusing to allow laboratory draws. The note identified, "Behaviors increased [due to] not getting med." R2's guardian was present, and typically was able to get R2 to have labs drawn, so the nursing home staff were seeking an order for the needed lab draw(s). An addendum was dictated by NP-B which identified, "I [NP-B] don't manage this, his psych provider orders this ... Upon calling site nurse back, site nurses stated that orders for labs no longer needed, now need okay to send to ED ... [R2] threw a traffic cone at his guardian. Guardian states that she has never seen [R2] as agitated and aggressive as he is right now, wants sent into ED. Facility staff also aren't able to manage behaviors at this time." A telephone order was provided to send R2 to the ED.

R2's corresponding ED Provider Notes, dated 11/3/20, identified R2 presented to the ED with a chief complaint listed as, "Aggressive behavior." R2 reported he was homeless before then voicing he resided at the nursing home, and also was recorded as throwing a telephone at one of the nurses. R2 voiced he was unaware why he had been sent to the ED, but did endorse having suicidal ideation. R2's needed laboratory draw(s) were completed and a behavioral consultation was completed and cleared him for discharge back to the nursing home. R2 was recorded as, " ... he is now willing to go back on his medications." Further, R2's Behavioral Access progress note, dated 11/3/20, identified R2 reported not taking his medications as they made him feel "stressed out." R2 voiced he would return to the nursing home and " ... be on my best

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behavior and I'll take my medicine." R2 denied command hallucinations to hurt himself or others, but acknowledged having visual hallucinations at times. Further, R2's clinical status was listed which identified highly impulsive and aggressive behavior(s) towards others. R2 was cleared to return to the nursing home.

On 11/4/20, a progress note identified R2 returned from the ER and had several labs, including a urinalysis completed. The results were negative for a bladder infection and no new medication or treatment orders were provided. The note concluded, "He is to see [nurse practitioner] in 2 days."

On 11/4/20, a subsequent progress note identified the pharmacy had been updated on the completed laboratory draws, and R2 " ... needed his Clozapine [sic] medication as soon as possible." The pharmacist voiced they would contact the hospital to review the laboratory results and would contact the nursing home. The note concluded, "Writer is awaiting call back from pharmacy." Further, an additional note, dated 11/4/20, identified the pharmacy was again contacted. The pharmacist voiced they needed more information on how many days R2 had been without his clozapine; which the nursing home expressed had been "two weeks since his last administration ..." The pharmacist then expressed they needed to speak with the provider who prescribed the medication to see if it needed to be re-titrated given the length of time R2 had been off the medication. The pharmacist voiced a message had been left for the provider, and the note concluded, "Writer is awaiting a respond from pharmacist ..."

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On 11/6/20, at 1:38 a.m. a progress note identified R2 was seen coming out of his room at approximately 11:30 p.m. (on 11/5/20) and voiced he was going to get a soda. The note continued, " ... When he didn't come back in 15 minutes ... asked CNA to go se if he was still by pop machine but CNA couldn't find him. Writer, nurse from east [sic] and 2 CNA's split up to check all rooms and other areas of the building ... [NA-A] found him raping a female resident and screamed for help. The 2 male CNA's pulled him off her and walked him back to his room. The DON [director of nursing] and charge RN were called. The police were called and the police took him about [1:30 a.m.]. For more details see VA [vulnerable adult] report."

R2's Medication Administration Record (MAR), dated 10/2020 to 11/2020, identified R2's physician ordered medications and their subsequent administration record(s). An order was listed for clozapine 500 milligrams (mg) everyday; which had a listed start date of 6/25/20. The medication was recorded as being given and consumed by R2 until 10/20/20. From 10/21/20 to 11/5/20, the MAR identified nearly all subsequent doses of the medication were not given with numerous entries of, "18," which was identified via legend as, "Med not available from pharmacy."

R2's Documentation Survey Report, dated 9/2020 to 11/2020, was reviewed and identified R2's recorded behaviors using a legend and corresponding code system. The report demonstrated R2 had no recorded behaviors, including hitting, threatening, cursing at others or sexually inappropriate behaviors, in the month of September and October 2020. However, R2 had

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a single episode of sexually inappropriate behavior recorded on 11/2/20 which was outlined as, "disrupted [the] environment." R2 was re-directed but the intervention was ineffective. The report lacked any further dictation on what the demonstrated sexual behavior was, and no other behaviors were recorded for R2 on these reports despite the repeated progress note(s) which identified him as cursing, throwing objects and wandering around the facility.

R2's medical record was reviewed and lacked evidence R2's escalating behaviors had been comprehensively assessed to help determine all contributing factors and subsequent interventions to help reduce and/or eliminate them despite the abrupt stopping of his prescribed antipsychotic medication. There was no evidence interventions had been implemented on a consistent basis to ensure R1 was adequately supervised and monitored to prevent altercations and potential abuse towards or from other residents despite R2 being independently mobile and ongoing documentation of escalating behaviors, including physically throwing items, hallucinating and being found masturbating in his room.

On 11/13/20, at 12:22 p.m. R2's appointed guardian (G)-A was interviewed. G-A stated she had been involved in R2's care for over the past year and explained R2 admitted to the nursing home in June 2020 for some rehabilitation therapy after a hospitalization. G-A described R2's mentation as "stable until he went off his meds" and outlined she felt he was doing "quite well" before 10/19/20. G-A expressed R2 had refused his laboratory draw which is what led him to not be provided his ordered antipsychotic medication and subsequently have worsening

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behaviors. G-A voiced she had never known or seen R2 to act with the demonstrated behaviors he had in the weeks prior to his arrest and subsequent discharge from the nursing home. G-A then recalled the events which led up to 11/6/20 and him sexually assaulting another resident. G-A was aware R2 had been found masturbating in his room on 11/2/20, and then expressed the facility had contacted her regarding moving R2 to a different room as he had previously been witnessed standing in the doorway of another resident's room and "making inappropriate sexual comments." However, the facility never provided the documentation to her of him doing that as it had just been expressed verbally to her by a staff member whom she could not recall. G-A stated she was not notified timely of R2 refusing the laboratory draw, nor the subsequent holding of his antipsychotic medications, which was frustrating to her as the nursing home should have contacted her and he could have been hospitalized or treated sooner before sexually assaulting someone. Further, G-A stated R2 was currently locked in jail with multiple charges pending against him from the sexual assault which made her upset as she believed the entire escalation of R2's behaviors and subsequent sexual assault on another resident could have been prevented if the facility had responded appropriately. G-A reiterated, "I believe this could have been prevented!"

R1's quarterly Minimum Data Set (MDS), dated 8/29/20, identified R1 had anxiety and depression, and had both long-term and short-term memory impairment. R1 was recorded as having no speech ability and was rarely, or never, able to understand others verbally. Further, R1 required extensive assistance with

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observation." The assessment lacked any identified interventions specific to R1's inability to call for help or report abuse (i.e. formal safety checks on a routine basis, doorway left open when not providing care, etc.).

R1's care plan, dated 11/6/20, identified R1 was considered vulnerable due to cognitive and physical impairments. The care plan listed a goal which read, "Resident will be provided a safe environment," along with three interventions which directed to observe for potential pain, discomfort or mental anguish; provide a safe environment, and, remove R2 from potentially abusive situations. These were the only interventions listed on the care plan prior to 11/6/20 to help ensure R1 remain free of abuse despite being identified on her Social Services Data Collection Assessment (dated 8/28/20) as being unable to report abuse and being at risk for abuse from others.

On 11/13/20, at 9:09 a.m. R1's family member (FM)-A was interviewed and recalled the incident from 11/5/20. FM-A explained he had been told another resident (R2) had "got into her [R1] room" and was "caught in the act" of sexually assaulting her. R1 was transported to the local hospital and a "rape kit" was completed which verified R1 had been sexually assaulted as they found injuries and bruising on R1's arms where the other resident "had pinned her back" while assaulting her. FM-A expressed relief the alleged perpetrator had been arrested and was "no longer allowed to come back" to the nursing home. Further, FM-A stated the nursing home had since moved R1 to a room closer to the nurses station to help her be more visible to the staff.

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R1's medical record identified the following:

On 11/6/20, a progress note identified R1 had left the facility for evaluation "after resident to resident incident." R1 returned to the nursing home on the same date.

R1's corresponding hospital Sexual Assault Community Care Plan, dated 11/6/20, identified R1 had been transported to the hospital. A "Date of Assault" was listed of 11/6/20, with a physical location of the nursing home recorded. A section labeled, "Patient Description of Assault," was outlined which identified information was gathered from NA-A, LPN-A and the St. Cloud Police Department which read, "[R1] found in room by [NA-A], being vaginally penetrated by assailant. Assailant was pinning her down by her arms ... it took 3 staff members to pull assailant off of patient ... reported that he [R2] was thrusting in and out of patient for about 5 minutes." The report explained R1 as " ... tensing up with nursing cares," at the hospital and versed (used to make patients feel relaxed before procedures) was given. R1 was recorded as grinding her teeth during the examination which the report dictated, "Guardian [FM-A] reported that [R1] grinds her teeth when in pain or distress." The report listed R1 as having visible petechiae (pinpoint, round spots that appear on the skin as a result of bleeding which can be due to localized trauma) to her arms and her left elbow region. The report outlined a vaginal examination was conducted which identified a reddened cervix, an abrasion to the clitoral head and hymen, and a laceration near the anus.

On 11/6/20, a subsequent progress note identified the social services department

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contacted FM-A whom consented for psychiatric services for R1. Further, FM-A was offered and accepted moving R1 to a different room which was closer to the nursing station as "... safety is more important than anything."

On 11/7/20, a progress note identified a nurse entered R1's room and comforted her. The note continued, "During this resident noted to get teary-eyed with some tears falling from face. Resident was observed to be grabbing at brief frequently. Oxycodone was administered to help relax resident."

On 11/10/20, a progress note outlined an order for psychiatric services had been obtained to evaluate and treat R1. R1's corresponding Associated Clinic of Psychology (ACP) Diagnostic Assessment, dated 11/9/20, identified a telephone visit was conducted to help evaluate R1's traumatic response following the sexual assault by R2 with dictation reading, "[R1] was recently sexually assaulted by a male resident and staff ask for psychological assessment to address ongoing trauma symptoms and concerns that may come to light post trauma." The report listed several recommendations for R1 which included having only female caregivers, observing for startle responses, and being closer to the nursing station. However, the completed report lacked any evident assessment of R1's vulnerability to continued abuse by others while residing at the nursing home.

On 11/13/20, at 9:41 a.m. NA-A was interviewed and explained R1 required total assistance from staff to complete her cares while R2 was more independent. NA-A then recalled the incident involving R1 and R2 from 11/5/20, and detailed

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R2 had left his room and voiced he was going to walk down to the soda machine. R2 was gone for "about 15 minutes" when the nurse working (RN-B) had asked staff to start looking for R2 as he had "been acting weird the last few days" and had not returned yet. NA-A stated a facility-wide search was started involving herself and several other staff members including NA-B and RN-A. While helping search for R2, NA-A stated she walked by R1's closed room door which made her pause and check inside as R1's door was usually left open at night as she was unable to verbally call for assistance, so staff tried to keep a closer eye on her room. NA-A opened R1's closed door and saw R2 on top of R1 in her bed. R2 had no pants or underwear on and was "holding her hands [down] on top of her" and "having sex with her." NA-A expressed R1's brief had been removed and R2's naked buttocks were visible immediately above her peri-area "moving up and down." NA-A stated she immediately yelled at R2 to "get off of her," but R2 just turned and looked at NA-A while he continued assaulting R1. NA-A then ran back into the hallway and called out loud for help from the male staff members who were standing in the hallway. They responded and removed R2 from R1's bed and took him to his room. NA-A explained the police were contacted and R2 was subsequently removed from the nursing home. Further, NA-A explained she had never known R2 to demonstrate sexual behaviors prior, but verified he was not on any formal supervision or monitoring despite being identified as "acting weird" the past few days.

When interviewed on 11/13/20, at 10:20 a.m. RN-B stated R1 was mostly non-verbal and typically remained in bed all night as she required total assistance from staff whom completed

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rounds on her "every two hours." RN-B described R2 as someone who "didn't need much care" and would often walk around the nursing home at night. RN-B stated R2 was not known to enter other resident's rooms to her knowledge. RN-B then recalled the incident involving R1 and R2 from 11/5/20, and explained R2 had come out of his room and voiced he was going to walk to the soda machine. R2 did not return after 15 to 20 minutes, so RN-B asked the floor staff to look for him as she wanted to make sure R2 did not accidentally wander onto the COVID-19 unit. They were initially unable to find him after searching the commons areas, so she directed the staff to begin checking each resident's room. RN-B was searching rooms on the North hallway when she "heard her [NA-A] scream" and responded. NA-A then told her R2 was found in R1's room and described the incident. R2 was removed and escorted back to his room, and RN-B stated she immediately contacted the DON who then provided instructions on how to handle the situation. The police department was contacted and responded whom then interviewed R2. The police then told RN-B that R2 had "admitted he had done it" and was then removed from the nursing home. RN-B recalled R2 never typically demonstrated any hallucinatory or aggressive behaviors which she could recall, however, voiced R2 had seemed to become "more restless" in the weeks leading up the 11/5/20 incident and R2's subsequent discharge from the nursing home. RN-B stated she was "not sure" why R2 had become more restless and expressed she "wasn't aware" there had been recorded notes outlining him as being aggressive or masturbating prior to the incident on 11/5/20; however, had learned of the notes since he was arrested and removed from the nursing home.

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Further, RN-B stated she had not received any education on how to handle sexual assaults or the facility's abuse prevention policies since the incident had happened.

During interview on 11/13/20, at 11:16 a.m. LPN-A stated he was familiar with R1 and R2, and described R2 as being an independent resident who mainly "[took] care of himself" and often stayed in his room. LPN-A recalled the incident from 11/5/20, and voiced he was working on the locked unit when two NA staff had approached him and asked if he had seen R2 who had not returned from getting a soda. LPN-A stated he offered to help them search for him when he heard NA-A scream and yell down the hallway, "He's raping her!" LPN-A stated he immediately ran down to R1's room and witnessed R2 on top of R1 in her bed with R2's pants, boxers and shoes on the floor. R1's night gown was pulled up and her brief had been opened. LPN-A stated he did not witness R2 penetrating R1, but vividly recalled R2 was "on top of her [R1] with his penis out" and "by her vagina." LPN-A added R2 was "attempting for sure" to have sexual intercourse with R1, if he had not already. R2 was immediately removed from R1 and they escorted him back to his room and told him his behavior and actions were "totally inappropriate." Further, LPN-A stated he was unaware of any specific education or guidance the facility had implemented since the assault; however, added there was a nursing meeting coming up in the next weeks and he was "hoping we're going to talk about that [the sexual assault incident]."

R1's medical record was reviewed and lacked evidence R1 had been comprehensively

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reassessed for her vulnerability since being sexually assaulted by R2 on 11/5/20, despite R1 being non-verbal and unable to report abuse or her physical impairment(s) resulting in a lack of being able to physically fight against a potential assailant.

On 11/13/20, at 1:07 p.m. registered nurse manager (RN)-A and licensed social worker (LSW)-A were interviewed. They explained R2 admitted to the nursing home after a hospitalization and planned to discharge to a venue of less care when able to. They described R2 as "calm and responsive" and never really identified him to have behaviors prior to the weeks leading up to the incident involving R1 on 11/5/20. LSW-A explained the facility typically reviewed a resident and their behaviors on a quarterly basis using "FOCUS meetings" along with a daily review completed through the stand-up meeting. They reviewed R2's FOCUS progress note (dated 10/15/20) and verified R2 displayed no hallucinations or aggressive behaviors at that time. They recalled "no major concerns" with him at the meeting adding they were actually unsure how they decided to record him as having restlessness and anxiety at that meeting. LSW-A stated the meetings were a newer process and they were still "trying to figure out" how to use them. RN-A explained R2 admitted using clozapine for his schizophrenia and consistently took the medication until 10/19/20, when he refused the routine laboratory monitoring and the pharmacist would not fill the prescription. RN-A explained the cart nurse then contacted R2's nurse practitioner (NP)-B a couple days later (on 10/22/20) who voiced she did not feel comfortable starting new medication or re-dosing the clozapine and directed an

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appointment with R2's psychiatry team should be made for as soon as possible. RN-A stated she then attempted to contact the psychiatric team via telephone, however, was unable to reach anyone so she left a message. A return call was never provided though and RN-A verified she never again attempted to contact the psychiatry provider as, at the time, she "didn't feel anybody was in immediate danger." They verified no increased supervision or monitoring had been placed on R2 despite abruptly stopping his antipsychotic medication; however, RN-A added such an intervention would be a good intervention to do for someone who abruptly ceased their medication. RN-A and LSW-A then reviewed R2's medical record and progress notes. They explained the behaviors being recorded after 10/19/20 were not normal behaviors R2 had demonstrated prior, and expressed no assessment or discussion of them had occurred at the daily stand-up meeting(s). RN-A voiced the floor nurses documenting the behaviors should be making sure the management team was aware of them and added they had "definitely not" been updated on these behaviors including the hallucinations, physical aggression and masturbation. LSW-A stated she did not "feel like I knew about all the behaviors" R2 was displaying. They then recalled the incident involving R1 and R2 from 11/5/20. LSW-A stated they had been told by a maintenance man who was working on 11/1/20 at the front desk that R2 had been seen standing outside R1's room. R2 was not demonstrating behaviors at the time, however, was merely just observed standing there and staring into her room. They acknowledged R2 was then found masturbating, according to the recorded progress notes, on 11/2/20 and reiterated they had not ever

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considered and assessed all the displayed behaviors R2 had since 10/19/20 when he abruptly stopped taking his antipsychotic medication. RN-A reiterated if they had been updated on the behaviors and known they were happening, they would have done some "more comprehensive assessment" of them and taken the situation "a little more seriously." LSW-A added she "didn't know the behaviors were escalating like that" and voiced she would have contacted the facility's psychiatry team (ACP) and tried to include them "if we [had been] aware of these crazy behaviors." RN-A and LSW-A verified no changes were made to R2's care plan, aside from a room change, from 10/19/20 until the incident involving R1 on 11/5/20 and added "maybe some education" was needed. Further, RN-A stated staff received training on abuse policies and procedures when they're hired and expressed a meeting to review the sexual assault of R1 and the missed behavior monitoring on R2 were maybe something "we need to address" in upcoming nurses meetings.

When interviewed on 11/13/20, at 3:12 p.m. NP-B described R2 as someone who was "very reserved" and "quiet" prior to 10/19/20, and NP-B verified she was "not aware of any behaviors" prior to the clozapine being stopped. NP-B explained she did not personally order or manage R2's clozapine as the prescriber is required to have a special certification as it was "a very dangerous medication." The medication required certain laboratory values to be checked periodically and, at times, pharmacies would not even release the medication until these lab(s) were obtained. As a result of those things, NP-B stated R2's psychiatry team was managing his ordered clozapine. NP-B explained when R2

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refused the laboratory monitoring on 10/19/20, their on-call provider service was notified about it a couple days later on 10/22/20. NP-B voiced no new medication orders were given as she assumed the nursing home had already been in touch with R2's psychiatry team and she would have "no idea" what they did or did not order. On 10/31/20, NP-B stated they were again notified R2's behaviors seemed to be worsening and, at that time, a three (3) day dose of clonazepam (a medication used for anxiety) was provided. Then on 11/3/20, NP-B was updated again and told R2 was now being very aggressive and had gone for "two weeks" without his antipsychotic medication. NP-B stated this was the first time she realized he had not had his clozapine "for awhile" and then ordered him to be evaluated in the ED as the nursing home felt they couldn't control him anymore. The ED completed the necessary laboratory draw(s) and, to her knowledge, the nursing home was working on getting his clozapine restarted when he returned to the facility on 11/4/20. NP-B expressed she was not aware R2's psychiatry team had never been notified of his refusal to allow the laboratory draw(s) and subsequent holding of his clozapine voicing that was "unfortunate." Further, NP-B voiced if she had been told R2's psychiatry service had not been updated and R2 had started on clonazepam sooner, it may "potentially" have helped to calm and reduce R2's behaviors before he required treatment in the ED and subsequently sexually assaulted a resident.

On 11/13/20, at 3:37 p.m. the consulting pharmacist (CP) was interviewed and explained clozapine was a medication typically used when other antipsychotics had not worked due to it's potentially dangerous "side effects" and required

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special laboratory monitoring to ensure safety while the patient is on it. CP voiced it "probably wouldn't be a good idea" to abruptly stop the medication without slowly titrating down prior, and doing so could yield the sudden return of schizophrenia symptoms or other adverse effects. Further, CP stated she was unaware of the specifics regarding R2 and his missed clozapine medication; however, explained if he had stopped taking the medication abruptly and then had a return of symptoms that perhaps a different antipsychotic to help reduce or calm the symptoms may have helped. CP added the nursing home should have a policy on what to do when the patient refuses medications and how to address it.

On 11/17/20, at 11:32 a.m. the director of nursing (DON) was interviewed and verified the administrator was off campus and not available for interview. The DON explained she received a telephone call shortly after midnight on 11/6/20, and the staff voiced "something terrible has happened." They explained R2 had left his room to get a soda which the DON described as "normal" for him to be "out and about" the unit at times; however, after several minutes he did not return so a facility-wide search was started. The staff then told her they found R2 and he was "raping our poor [R1]." The DON instructed them to contact the police department and then contacted and updated the administrator on the allegation. R1's guardian was contacted and she was sent to the hospital for examination. The DON voiced when she arrived at the nursing home, the police were present and voiced R2 was going to be arrested for "sexual misconduct" as R2 admitted to the police he committed the act; however, the DON said nobody provided

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further details. R1 returned from the hospital and the DON verified R1's findings, including the injuries on her skin and vaginal examination, were not present prior to the sexual assault on 11/5/20. The DON then verified the hallway(s) of the nursing home were video monitored and the feed from the allegation time-frame was reviewed with the surveyor which revealed the following:

On 11/5/20, at 11:24 p.m. R2 comes visible into the camera and walks past NA-B. R2 then turns his head and looks back at NA-B before he turns the corner to go down the section of hallway where R1 resides. The DON voiced R2 turning his head to look at NA-B looked "suspicious to [her]." R2 then walks down the hallway and is seen entering R1's room at 11:25 p.m. The doorway to R1's room is not visible in the feed; however, the DON verified R2 closed the doorway immediately after he entered the room. Approximately 15-20 seconds later, NA-B is visible coming around the corner and walking past R1's room without stopping or looking at the room. At 11:48 p.m. NA-B again walks by R1's room and does not stop or enter the room despite the doorway being closed. At 11:56 p.m. (31 minutes after R2 entered R1's room) NA-A is visible entering R1's room and almost immediately comes back into the hallway while gesturing to the staff standing down at the end of the hallway. The staff run to R1's room and enter. At 11:57 p.m. R2 is visible being escorted out of R1's room wearing only a shirt as the staff escorting him hold a towel over his genitals and waist. There is no recorded sound for the entirety of the video clips.

The interview with the DON continued and she voiced given the information they gathered from

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interviews with the direct care staff and R1's hospital records, they determined "sexual misconduct" had happened and added, "He [R2] raped her [R1]." When questioned on the action(s) taken to protect R1 when R2 had been seen by the maintenance personnel standing outside R1's room on 11/1/20, the DON explained the staff reported to her on 11/2/20 that R2 "was creepy" and had been seen standing in the vicinity of R1's room. The DON expressed the maintenance staff described it as R2 was standing by "the little girls room." The DON voiced it was hard to determine if R2 was actually standing at R1's door or just by her room as R2's old room was close to hers and added they did not react abruptly to the comment as just voicing someone as "creepy" isn't an overly concerning comment by itself. However, they then decided to move R2 to a different room as they didn't want R2 to have altercations with roommates over the bathroom or television volume which had happened in the past. The DON stated they had reviewed camera footage since the incident on 11/5/20, and they were unable to locate the incident of R2 standing outside R1's room despite the maintenance man reporting it had happened and they questioned if he was reporting the situation accurately. Regardless, the DON verified no formal supervision or safety checks were placed on R2 despite him abruptly stopping his antipsychotic medication, having documented escalating behaviors and potentially being found standing outside R1's room and staring at her. The DON stated masturbation, in itself, may or may not be considered behavioral as he could have been doing the act in private many times before; however, she did voice she had no knowledge of him being found doing it by staff throughout his stay prior to 11/2/20. The DON

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expressed R2 had no prior history of sexual behaviors to their knowledge, but rather he was "unpredictable" at times and would be aggressive if irritated. The DON then explained she had heard about R2 not getting his scheduled clozapine when standing out by the nurses station and a nurse reported they did not have the medication to give adding she was "pretty confident" she had not been told of it until the week just prior to the sexual assault of R1. The DON voiced her expectation would have been to be informed the same day R2 initially refused the laboratory draw and subsequently had his medication not provided, and stated she directed staff to ensure the guardian and NP-B were updated on the situation. The staff attempted several times to draw the needed laboratory tests, but R2 would not allow it. The DON then reviewed R2's progress note(s) in his medical record verified there were "more behaviors documented" after 10/19/20, and added her expectation was for RN-A and LSW-A to review the progress notes "each day" and bring concerns, like escalating behaviors and missed medications, to the IDT meeting so they can be reviewed and addressed including reviewing for possible triggers, patterns and other issues. The DON verified R2's missed doses of clozapine were never raised at their IDT meetings and explained had the issues been presented at the meeting, she "would have intervened" and made sure appropriate action was taken adding RN-A and LSW-A were responsible to ensure the behaviors were assessed and "put all that together." The DON stated those assessments would have lead to multiple interventions which could have then been attempted to help ensure residents, including R2 himself, were kept safe and protected from his escalating behaviors. The

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DON stated she felt the escalating behaviors, and subsequent sexual assault of R1, could not have been avoided since R2 had never displayed sexual behaviors and had no history of entering female resident rooms it was not "something we could have predicted." Further, the DON voiced she had just completed some education with RN-A and LSW-A on her expectations for behavioral monitoring and progress note review; however, they had not started any audits or other "more formal" education with other nurses and staff as they were going to review everything through their IDT.

A provided SA 'Five-Day' investigation, dated 11/12/20, identified the facility' completed investigation they submitted to the SA. This report identified the facility had reviewed R1 and R2's care plans, diagnoses, charting and cognitive status in their investigation into the allegation. R1's care plan was listed as being followed at the time of the incident and listed the ACP recommendations (dated 11/9/20) as being implemented. The report identified LSW-A interviewed six other "alert and orientated" residents for concerns with any unwanted male residents in their room and all six denied concerns; and, five cognitively impaired residents had a skin assessment completed, and monitoring for mood and pain implemented, to help screen for potential concerns. The report identified this as "a one-time incident," and continued with dictation reading, "Our investigation also revealed that staff responded timely and appropriately to the incident, and that it is implausible that interventions could have been known to have been put into place to avoid this incident." Further, the report identified R1 was harmed as a result of the sexual assault and R2

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had been discharged from the facility. However, the completed investigation lacked any evidence or information on R2's documented, escalating behaviors or what, if any, interventions had been implemented to address them prior to the sexual assault; nor did the report have any evidence the facility had comprehensively reassessed R1's vulnerability to potential abuse, including sexual abuse, from others and their actions to ensure she remained adequately supervised and safe.

When interviewed on 11/17/20, at 9:08 a.m. maintenance staff (M)-A verified he was working the front desk on 11/1/20, and recalled seeing R2 roaming in the hallway "around 6:00 a.m." M-A voiced R2 was "a little bit creepy," so he asked the NA(s) working why R2 roamed around so often. M-A said he merely reported R2 to the NA then and from there it was "her responsibility" to watch him. M-A voiced he did not recall seeing R2 standing outside of R1's doorway, but added his English was poor, at times, and he sometimes "found it a little hard to describe something" to others.

On 11/17/20, at 1:56 p.m. the DON and LSW-A were interviewed and voiced a resident's vulnerability to abuse should be "assessed routinely" by the social worker. They explained as part of their follow-up to the sexual assault of R1, they had R1 seen by their facility' contracted psychiatric service and they focused on visiting with other female residents on if they had experienced an "unwanted interactions." The DON stated the nursing department was focusing on completing skin assessments to rule out injuries on people which may be consistent or suspicious for abuse. LSW-A explained the facility completed a routine vulnerability

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assessment on a quarterly basis which helped determine if abuse was present or if someone was at risk for abuse by reviewing "a whole list of things" such as sensory impairment and if someone was able to even report abuse. However, LSW-A then verified she had not formally reassessed R1, or any other residents, since the incident on 11/5/20 to help ensure they remained free of abuse. LSW-A voiced ACP (the facility's contracted psychology clinic) had reviewed R1 since the incident and made some recommendations for her ongoing care, including female only caregivers, but verified their documentation lacked reassessment of R1's vulnerability to abuse from others. LSW-A stated she felt the "biggest thing" the facility did to help her stay safe was to move her room to be closer to the nurses station; however, acknowledged a reassessment of her vulnerability would be of benefit and would help ensure "certain things" to keep R1 safe were on the care plan including potential safety checks. Further, LSW-A stated she "had not seen that" progress note (dated 11/7/20) which outlined R1 has tearful and grabbing at her brief since the incident, however, voiced she had spent some time with R1 in the recent days and did not personally see anything concerning with her demeanor.

During the abbreviated survey, from 11/13/20 to 11/18/20, multiple phone calls were attempted to interview NP-A regarding R2's behavior and the incident which happened on 11/5/20, where R2 was found in R1's room sexually assaulting her. A missed return call was provided on 11/18/20, and a message was left indicating a telephone interview would not be possible until 12/2/20. On 12/2/20, at 1:41 p.m. NP-A was interviewed and verified she helped oversee his psychiatric care

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for the duration of his nursing home admission. NP-A described R2 as a "very poor historian" who often displayed poor insight into his own mental health. NP-A recalled seeing R2 in person on 8/27/20, where a staff person was present and voiced R2 was doing well overall and having no concerning behaviors. NP-A stated their clinic was notified on 10/19/20, when R2 refused his laboratory draw and pharmacy would not fill his ordered clozapine; however, NP-A was on vacation at the time so she was not personally updated. NP-A stated the nursing home should have re-contacted them if no phone call was received back as someone stopping clozapine abruptly could demonstrate a return of their psychotic symptoms adding R2 appeared to have been off his clozapine for "about 15 days" when he was arrested. NP-A stated she was unaware of R2's escalating behaviors after 10/19/20, and voiced had their clinic been updated, they would have started other medications as "their were options available." NP-A expressed many antipsychotic medications, including clozapine, have side effects which can reduce sexual urge or desire and if they're abruptly stopped it could contribute to those desires returning, adding had R2 been medicated appropriately it may have "helped him to make better decisions" and potentially not sexually assault a female resident.

A provided Vulnerable Adult Abuse and Neglect Prevention policy, dated 9/11/20, identified a purpose of providing a safe environment for residents which is " ... free from harm." The policy outlined all residents were susceptible to potential abuse and all residents would be kept safe and remain free from abuse while residing at the nursing home. The policy outlined a section labeled, "Prevention," which directed the facility

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F 600	Continued From page 38 would intervene in situations where abuse would be likely to occur. This included analysis and, "The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors," and, " ... residents with communication disorders, those that requires [sic] heavy nursing care and/or are totally dependent staff." In addition, a separate, "Procedures for an Allegation of Sexual Abuse," was affixed which outlined a procedure to be implemented should an allegation of sexual abuse happen. This procedure included removing the resident from the accused, assessing them for injury, and sending them to the hospital for evaluation. Further, the procedure outlined, "When resident (victim) returns from the hospital, the [IDT] should meet with resident and re-assess resident's plan of care." The IJ which began on 10/19/20, was removed on 11/18/20, when the facility successfully implemented a removal plan which included comprehensively reassessing R1's vulnerability to abuse from others; reassessing others identified at risk for abuse for their vulnerabilities to potential abuse; and educating staff on the facility's abuse prevention policy along with behavioral management and procedures when medications and/or treatments are refused. On 11/18/20, from 3:45 p.m. to 4:29 p.m. interviews with direct care staff and management verified training on abuse, including signs and symptoms of potential abuse, along with behavioral management and resident refusal of medication and treatments had been completed.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		12/23/20

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F 610	Continued From page 39 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R1) reviewed who had been sexually assaulted was cared for in a manner which would help preserve evidence and not potentially impede a criminal investigation and/or sexual assault examination. Findings include: A submitted state agency (SA) Incident Report, dated 11/6/20, identified a facility' reported allegation of sexual abuse involving R1 when another resident had been found in R1's room " ... having sexual intercourse" with her. The report outlined the police were contacted and the alleged perpetrator (AP) was removed from the nursing home while R1 was transported to the hospital for evaluation.	F 610	" R1 had a SANE assessment completed on 11/6/2020 and the incontinence product which had been removed from resident R1 was retrieved and provided to the police. " Residents who are victims of a crime are at risk of being affected. Vulnerability assessments completed and found no other resident who are currently victims of a crime. " Nursing home staff educated on the importance of securing a crime scene until police arrive. " Weekly audits for 2 months for monitoring for residents who are victims of a crime to ensure the crime scene is secure will be completed. If there are no residents who have been a victim of a	

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F 610	Continued From page 40 R1's quarterly Minimum Data Set (MDS), dated 8/29/20, identified R1 had anxiety and depression, and had both long-term and short-term memory impairment. R1 was recorded as having no speech ability and was rarely, or never, able to understand others verbally. Further, R1 required extensive assistance with her activities of daily living (ADLs). R1's progress note, dated 11/6/20, identified R1 had left the facility for evaluation "after resident to resident incident." R1 returned to the nursing home on the same date. R1's corresponding hospital Sexual Assault Community Care Plan, dated 11/6/20, identified R1 had been transported to the hospital after being found, " ... in room by [nursing assistant (NA)-A], being vaginally penetrated by assailant. Assailant was pinning her down by her arms ... it took 3 staff members to pull assailant off of patient ... reported that he [R2] was thrusting in and out of patient for about 5 minutes." Further, a section of the report labeled, "Post-Assault Activity," identified R1's pull-up brief had been changed prior to her hospitalization, and, "peri-area cleaned with wipes at [nursing home]." When interviewed on 11/13/20, at 9:41 a.m. NA-A verified she was the NA who found R1 being sexually assaulted by another resident on 11/5/20. NA-A stated she found a male resident naked on top of R1 with her brief down with his buttocks visibly going "up and down" over her peri-area. The male resident was removed from R1 and taken to his room, however, NA-A voiced the nurse working had directed her to "clean her [R1] up" before she was sent to the hospital.	F 610	crime, conduct staff interviews to validate staff knowledge of securing a crime scene. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation " NHA/Designee is responsible	

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NA-A verified she then used a wipe to clean R1's vagina and placed a new brief on her before she was sent to the hospital; however, voiced she did not recall any visible fluids being present when she cleaned her.

During interview on 11/13/20, at 10:10 a.m. registered nurse (RN)-B stated she was working with NA-A when the incident of R1 being sexually assaulted happened on 11/5/20. RN-B recalled asking NA-A to place a new brief on R1; however, denied ever directing her to clean her prior to R1 being sent to the hospital for a sexual assault examination. RN-B stated it "never even occurred to [her]" to save the brief R1 had been wearing when the assault happened. However, the hospital called back to the nursing home and they were able to retrieve the brief from the trash basket and send it over to the hospital.

On 11/17/20, at 11:32 a.m. the director of nursing (DON) was interviewed and verified R1 had been sexually assaulted by another resident at the nursing home. The DON explained NA-A should not have cleaned R1 up following the incident as it was not the facility policy and staff need to act in a way "to preserve evidence" of a potential crime. Further, the DON expressed they had planned to do some education with the staff on the subject; however, it had not been completed thus far.

A provided Vulnerable Adult Abuse and Neglect Prevention policy, dated 9/11/20, identified an attached procedure titled, "Procedures for an Allegation of Sexual Abuse," which directed a series of steps to be done after an allegation is made. This included, "Do not shower or change resident," and, "Do not discard clothing or bed

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F 610	Continued From page 42 linen ... Preserve both parties clothing and linen for possible crime scene." The policy lacked any guidance or dictation on the use of wipes on an assault victim.	F 610		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate care and obtain physician orders and/or guidance from an outside psychiatric physician group to ensure mental health needs were addressed for 1 of 1 residents (R2) reviewed who refused laboratory monitoring and subsequently had their ordered antipsychotic medications held for an extended period of time. Findings include:	F 710	" R2 was discharged from the facility on 11/6/2020. " Residents who refuse their psychotropic medications, treatments, or labs have the potential to be affected if their physician is not notified of the refusals. Residents with psychotropic medications will be monitored daily on business days for any refusals of psychotropic medications, treatments, or labs. If patterns of refusals occur, the	12/23/20

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F 710	Continued From page 43 R2's quarterly MDS, dated 9/29/20, identified R2 had schizophrenia (a disorder which affects a person's ability to think, feel, and behave clearly) and moderate cognitive impairment. Further, R2 demonstrated no hallucinations, delusions or rejection of care behaviors, and required only supervision with ambulation in the corridor and his room. R2's care plan, dated 10/5/20, identified R2 had a communication deficit and directed staff to, "Anticipate and meet needs." Further, R2 was identified to consume antipsychotic medication and listed a goal of being free of psychotropic medication related complications. The care plan listed several interventions to help R2 meet this goal including, but not limited to, administering the medication(s) as ordered, consulting with the pharmacist and physician on potential dose reductions, and monitoring for adverse side effects including agitation and restlessness. R2's medical record, including progress notes, were reviewed and identified the following: On 10/19/20, a progress note identified the pharmacy came to deliver R2's antipsychotic medication and draw routine laboratory work. R2 refused and threw his coffee at the employee. The note outlined, "Pharmacy unable to delivery [sic] medication since resident refused lab draw." The note identified registered nurse (RN)-A was updated. On 10/22/20 (three days later), a progress note identified R2 had refused the laboratory draw on 10/19/20, and it was ordered they continue to re-approach R2 and attempt to obtain the lab(s) so R2's clozapine prescription could be filled. A	F 710	physician will be notified of the refusals. " Licensed nursing staff/TMA educated on the importance of identifying refusals and notifying the physician of the refusals. " Weekly audits for 2 months for residents with psychotropic medications for a pattern of refusals of the psychotropic medications, treatments or labs will be completed to validate that the physician has been notified of the refusal. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation " DON/Designee is responsible	

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corresponding Genevive (Physician Group) Progress Note, dated 10/22/20, identified R2's medical nurse practitioner (NP)-B was updated on R2's refusal to allow the laboratory draw on 10/19/20, so no medication was available for administration as a result. R2 was listed as consuming 500 mg of clozapine everyday. The note outlined NP-B responded, "Please call and tell [nursing home] to keep trying with labs. His psychiatrist is the ordering provider I believe."

On 10/23/20, a late-entry progress note was recorded which identified NP-B had been updated on R2's refusal to allow laboratory draw(s) for his clozapine. The note continued, "NP[-B] wanted nystrom appointment made ASAP [as soon as possible]. Nystrom [psychiatry clinic] appointment made for 11/12/20."

On 10/31/20, a progress note identified R2 came and sat by the 'West Desk.' R2 was questioned if he needed anything by the staff, but then " ... began yelling at writer to shut up. After a few minutes a [NA] came down the hallway and he looked at her and yelled 'you fucking nigger' X3 [three times]." R2 was recorded as spending "a good portion" of the day outside of his room walking around, including standing by the front door and pushing buttons in attempt to open it. The note lacked any evidence of interventions attempted by the staff to calm or redirect R2 despite these behaviors.

On 11/1/20, a progress note identified R2 was recorded as being, " ... very agitated, restless and having hallucinations during shift ... [nurse] waved at him and resident flicked nurse off, said 'fuck you' ... drew his arm back as if acting he was going to punch nurse." The note continued, "This

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is very abnormal behavior for resident." The nurse sat down next to R2 and talked with him which was effective in calming him down. The note identified the laboratory had attempted to draw R2's lab(s) on the prior shift which " ... is what caused resident to become upset." R2 was provided education on the importance of the lab draw, however, the note outlined R2 continued to be observed as restless but without physical aggression or agitation. The note continued, "[R2] approached nurse stating 'I am hearing voices.' Nurse asked what the voices were telling him and resident replied 'That no one likes me, everyone hates me, and that I should just die." The note identified the nurse provided comfort to R2 whom proceeded to hug the nurse and become upset and start crying. Genevive (physician service) was contacted due to R2's continued restlessness and an order for clonazepam 0.5 mg twice a day as-needed was provided for a three (3) day period " ... until cozapine issue was resolved." This was administered to R2 and the note recorded, " ... appeared to have effectiveness." R2's corresponding Genevive Phone Encounter note, dated 10/31/20, identified the nursing home had contacted the service reporting R2 " ... is experiencing increased agitation, aggression and hallucinations ... patient was receiving Clozapine [sic], though a script has not been sent as they are waiting for lab work to be completed, though patient continues to refuse labs ... staff are concerned for his agitation." The note identified an order for clonazepam 0.5 mg twice a day as-needed for three days was provided along with, "Nursing staff are to follow-up with patient's PCP [primary care provider] this week regarding his agitation."

On 11/1/20, another progress note was recorded

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which identified R2 was " ... noted to be pacing around facility through out the morning. Per [night shift] report, resident was up all night pacing and did not sleep. Resident asking staff to purchase cigarettes for him. Yelling at staff 'I can smoke if I want! I'm over 18!' Emotional support and reassurance provided. Resident then approached staff member at front desk. Became upset with staff member when unable to get cigarettes and threw desk supplies across lobby." The note outlined education and encouragement was provided, however, R2 " ... Becomes more and more angry as staff re-approach." R2 was then provided time and space to express his feelings and " ... appeared to calm down but continues to refuse medications."

On 11/2/20, a progress note identified staff entered R2's room and R2 " ... had his pants off and was laying in bed. [R2] was masturbating." R2 proceeded to cover himself and the nurse provided R2 his oral pills when R2 then " ... put his right hand around the writers clavicle area then took his hand away and started to laugh." The note identified the nurse explained it was not appropriate to grab them in such a manner and left the room.

On 11/2/20, a subsequent progress note identified, "New behavior symptom noted. Behavior addressed with NP and guardian."

On 11/3/20, a progress note identified order(s) were received from NP-B to send R2 to the emergency room (ER). A subsequent note, dated 11/3/20, identified R2 had met with his guardian (G)-A and the nurse attempted to get the needed laboratory draw completed while she was present. The note recorded, " ... resident yelled

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'Fuck you, you ain't taking any labs', then resident picked up an orange traffic cone and threw it at his guardian." NP-B was updated regarding the continued inability to draw the needed lab(s) and R2 " ... had been off his clozapine for almost two weeks, and that writer believed resident needed to be sent in to the hospital for further evaluation." R2 was sent to the hospital ER via ambulance. R2's corresponding Genevive Progress Note, dated 11/3/20, identified NP-B was contacted as R2 had gone without his ordered clozapine for two weeks as he was refusing to allow laboratory draws. The note identified, "Behaviors increased [due to] not getting med." R2's guardian was present, and typically was able to get R2 to have labs drawn, so the nursing home staff were seeking an order for the needed lab draw(s). An addendum was dictated by NP-B which identified, "I [NP-B] don't manage this, his psych provider orders this ... Upon calling site nurse back, site nurses stated that orders for labs no longer needed, now need okay to send to ED ... [R2] threw a traffic cone at his guardian. Guardian states that she has never seen [R2] as agitated and aggressive as he is right now, wants sent into ED. Facility staff also aren't able to manage behaviors at this time." A telephone order was provided to send R2 to the ED.

R2's ED Provider Notes, dated 11/3/20, identified R2 presented to the ED with a chief complaint listed as, "Aggressive behavior." R2 reported he was homeless before then voicing he resided at the nursing home, and also was recorded as throwing a telephone at one of the nurses. R2 voiced he was unaware why he had been sent to the ED, but did endorse having suicidal ideation. R2's needed laboratory draw(s) were completed and a behavioral consultation was completed and

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cleared him for discharge back to the nursing home. R2 was recorded as, " ... he is now willing to go back on his medications." Further, R2's Behavioral Access progress note, dated 11/3/20, identified R2 reported not taking his medications as they made him feel "stressed out." R2 voiced he would return to the nursing home and " ... be on my best behavior and I'll take my medicine." R2 denied command hallucinations to hurt himself or others, but acknowledged having visual hallucinations at times. Further, R2's clinical status was listed which identified highly impulsive and aggressive behavior(s) towards others. R2 was cleared to return to the nursing home.

On 11/4/20, a progress note identified R2 returned from the ER and had several labs, including a urinalysis completed. The results were negative for a bladder infection and no new medication or treatment orders were provided. The note concluded, "He is to see [nurse practitioner] in 2 days."

On 11/4/20, a subsequent progress note identified the pharmacy had been updated on the completed laboratory draws, and R2 " ... needed his Clozapine [sic] medication as soon as possible." The pharmacist voiced they would contact the hospital to review the laboratory results and would contact the nursing home. The note concluded, "Writer is awaiting call back from pharmacy." Further, an additional note, dated 11/4/20, identified the pharmacy was again contacted. The pharmacist voiced they needed more information on how many days R2 had been without his clozapine; which the nursing home expressed had been "two weeks since his last administration ..." The pharmacist then expressed they needed to speak with the provider

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who prescribed the medication to see if it needed to be re-titrated given the length of time R2 had been off the medication. The pharmacist voiced a message had been left for the provider, and the note concluded, "Writer is awaiting a respond fro pharmacist ..."

On 11/6/20, at 1:38 a.m. a progress note identified R2 sexually assaulted a female resident and was removed from the facility by the police.

R2's Medication Administration Record (MAR), dated 10/2020 to 11/2020, identified R2's physician ordered medications and their subsequent administration record(s). An order was listed for clozapine 500 milligrams (mg) everyday; which had a listed start date of 6/25/20. The medication was record as being given and consumed by R2 until 10/20/20. From 10/21/20 to 11/5/20, the MAR identified nearly all subsequent doses of the medication were not given with numerous entries of, "18," which was identified via legend as, "Med not available from pharmacy."

R2's medical record was reviewed and lacked evidence R2 escalating behaviors were communicated to R2's psychiatry team for new physician orders or direction despite him refusing the laboratory draw and subsequently having his prescribed antipsychotic medication held since 10/20/20.

On 11/13/20, at 1:07 p.m. registered nurse manager (RN)-A and licensed social worker (LSW)-A were interviewed. R2 admitted to the nursing home after a hospitalization and planned to discharge to a venue of less care when able to. They described R2 as "calm and responsive" and

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never really identified him to have behaviors prior to the weeks leading up to the incident involving a female resident on 11/5/20. RN-A explained R2 admitted using clozapine for his schizophrenia and consistently took the medication until 10/19/20, when he refused the routine laboratory monitoring and the pharmacist would not fill the prescription. RN-A explained the cart nurse then contacted R2's nurse practitioner (NP)-B a couple days later (on 10/22/20) who voiced she did not feel comfortable starting new medication or re-dosing the clozapine and directed an appointment with R2's psychiatry team should be made for as soon as possible. RN-A stated she then attempted to contact the psychiatric team via telephone, however, was unable to reach anyone so she left a message. A return call was never provided though and RN-A verified she never again attempted to contact the psychiatry provider as, at the time, she "didn't feel anybody was in immediate danger."

On 11/13/20, at 3:12 p.m. R2's medical nurse practitioner (NP)-B was interviewed. R2 was someone who was "very reserved" and "quiet" prior to 10/19/20, and NP-B verified she was "not aware of any behaviors" prior to the clozapine being abruptly stopped. NP-B explained she did not personally order or manage R2's clozapine as the prescriber is required to have a special certification as it was "a very dangerous medication." The medication required certain laboratory values to be checked periodically and, at times, pharmacies would not even release the medication until these lab(s) were obtained. As a result of those things, NP-B stated R2's psychiatry team was managing his ordered clozapine. NP-B explained when R2 refused the laboratory monitoring on 10/19/20, their on-call

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provider service was notified about it a couple days later on 10/22/20. NP-B voiced no new medication orders were given as she assumed the nursing home had already been in touch with R2's psychiatry team and she would have "no idea" what they ordered or did. On 10/31/20, NP-B stated they were again notified R2's behaviors seemed to be worsening and, at that time, a three (3) day dose of clonazepam (a medication used for anxiety) was provided. Then on 11/3/20, NP-B was updated again and told R2 was now being very aggressive and had gone for "two weeks" without his antipsychotic medication. NP-B stated this was the first time she realized he had not had his clozapine "for awhile" and then ordered him to be evaluated in the ED as the nursing home felt they couldn't control him anymore. The ED completed the necessary laboratory draw(s) and, to her knowledge, the nursing home was working on getting his clozapine restarted when he returned to the facility on 11/4/20. NP-B expressed she was not aware R2's psychiatry team had never been notified of his refusal to allow the laboratory draw(s) and subsequent holding of his clozapine voicing that was "unfortunate."

When interviewed on 11/17/20, at 11:32 a.m. the director of nursing (DON) explained she had heard about R2 not getting his scheduled clozapine when standing out by the nurses station and a nurse reported they did not have the medication to give. She could not recall the exact date she was first told R2 had not been getting his prescribed clozapine, but felt "pretty confident" she was not told until the week just prior to the sexual assault of the female resident on 11/5/20. The DON voiced her expectation would have been to be informed the same day he initially

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refused the laboratory draw and subsequently had his medication not provided.

During the abbreviated survey, from 11/13/20 to 11/18/20, multiple phone calls were attempted to interview NP-A regarding R2's behavior and the incident which happened on 11/5/20, where R2 was found in R1's room sexually assaulting her. A missed return call was provided on 11/18/20, and a message was left indicating a telephone interview would not be possible until 12/2/20. On 12/2/20, at 1:41 p.m. NP-A was interviewed and verified she helped oversee his psychiatric care for the duration of his nursing home admission. NP-A described R2 as a "very poor historian" who often displayed poor insight into his own mental health. NP-A stated their clinic was notified on 10/19/20, when R2 refused his laboratory draw and pharmacy would not fill his ordered clozapine; however, NP-A was on vacation at the time so she was not personally updated. NP-A stated the nursing home should have re-contacted them if no phone call was received back as someone stopping clozapine abruptly could demonstrate a return of their psychotic symptoms adding R2 appeared to have been off his clozapine for "about 15 days" when he was arrested. NP-A stated she was unaware of R2's escalating behaviors after 10/19/20, and voiced had their clinic been updated, they would have started other medications as "their were options available."

A provided Physician Services policy, dated 3/27/20, identified each resident must remain under the care of a physician while admitted to the nursing home. Further, the policy directed a resident's attending physician was responsible to prescribing new therapy, however, they could

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F 710	Continued From page 53 delegate task(s) to the nurse practitioners, as desired. The policy lacked any direction or guidance on coordination of physician care with outside providers when the attending staff are unable to prescribe needed therapies or medications.	F 710		
F 740 SS=G	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure escalating behaviors were appropriately assessed and interventions implemented to ensure safety and reduce the risk of adverse events for 1 of 1 residents (R2) reviewed who demonstrated increased physical aggression and hallucinations after abruptly stopping their antipsychotic medication. This resulted in actual psychosocial harm for R2 when the lack of assessment and interventions contributed to escalating behaviors and the sexual assault of another resident resulting in R2's imprisonment. Findings include:	F 740	" R2 was discharged from the facility on 11/6/2020. " Residents who refuse their psychotropic medications, treatments, or labs and have noted increase or change in behaviors have the potential to be affected if new interventions and monitoring is not put into place. Residents with psychotropic medications will be monitored daily on business days for any refusals of psychotropic medications, treatments, or labs and for any increase or changes in behavior. If patterns of refusal and behaviors occur, the team will review and ensure interventions and monitoring are put into place.	12/23/20

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F 740	Continued From page 54 A submitted state agency (SA) Incident Report, dated 11/6/20, identified a facility' reported allegation of sexual abuse involving R2 sexually assaulting another resident. The report outlined R2 had been found in the resident's room " ... having sexual intercourse." The report outlined the police were contacted and removed R2 from the facility. Further, the report listed several witnesses to the allegation which included nursing assistant (NA)-A, NA-B, licensed practical nurse (LPN)-A and registered nurse (RN)-B. On 11/13/20, at 12:22 p.m. R2's appointed guardian (G)-A was interviewed. G-A stated she had been involved in R2's care for over the past year and explained R2 admitted to the nursing home in June 2020 for some rehabilitation therapy after a hospitalization. G-A described R2's mentation as "stable until he went off his meds" and outlined she felt he was doing "quite well" before 10/19/20, when his prescribed clozapine (an antipsychotic medication) was stopped abruptly. G-A expressed R2 had refused his laboratory draw which is what led him to not be provided his ordered antipsychotic medication and subsequently have worsening behaviors. G-A voiced she had never known or seen R2 to act with the demonstrated behaviors he had in the weeks prior to his arrest and subsequent discharge from the nursing home. G-A then recalled the events which led up to 11/6/20 and him sexually assaulting another resident. G-A was aware R2 had been found masturbating in his room on 11/2/20, and then expressed the facility had contacted her regarding moving R2 to a different room as he had previously been witnessed standing in the doorway of another resident's room and "making inappropriate sexual comments." However, the facility never provided	F 740	" Licensed nursing staff and Social Worker educated on the importance of identifying refusals, monitoring for changes or increased behaviors, and putting interventions/monitoring in place. " Weekly audits for 2 months for residents with psychotropic medications for refusals of the psychotropic medications, treatments or labs will be completed to validate that the interventions and monitoring are in place. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation " DON/Designee is responsible	

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the documentation to her of him doing that as it had just been expressed verbally to her by a staff member whom she could not recall. G-A stated she was not notified timely of R2 refusing the laboratory draw, nor the subsequent holding of his antipsychotic medications, which was frustrating to her as the nursing home should have contacted her and he could have been hospitalized or treated sooner before sexually assaulting someone. Further, G-A stated R2 was currently locked in jail with multiple charges pending against him from the sexual assault which made her upset as she believed the entire escalation of R2's behaviors and subsequent sexual assault on another resident could have been prevented if the facility had responded appropriately. G-A reiterated, "I believe this could have been prevented!"

R2's quarterly MDS, dated 9/29/20, identified R2 had schizophrenia (a disorder which affects a person's ability to think, feel, and behave clearly) and moderate cognitive impairment. Further, R2 demonstrated no hallucinations, delusions or rejection of care behaviors, and required only supervision with ambulation in the corridor and his room.

R2's most recent Psychotropic Medication Review and Evaluation, dated 9/22/20, identified R2 had schizophrenia and consumed several psychotropic medications including loxapine (an antipsychotic), clonazepam (used to reduce anxiety), and clozapine. The form listed a primary target behavior which read, "Hearing voices." This was listed as happening every two weeks. The assessment listed a radio-button style question which read, "Do these behaviors cause the resident to present a danger to themselves or

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others ... of interfere with the staff's ability to give care?" This was answered, "No." Further, the assessment identified R2's behaviors and management as, "Controlled."

R2's care plan, dated 10/5/20, identified R2 had a communication deficit and directed staff to, "Anticipate and meet needs." R2 consumed antipsychotic medication and the care plan listed a goal of being free of psychotropic medication related complications with several interventions to help R2 meet this goal including, but not limited to, administering the medication(s) as ordered, consulting with the pharmacist and physician on potential dose reductions, and monitoring for adverse side effects including agitation and restlessness. Further, the care plan identified R2 was considered a vulnerable adult due to his cognitive impairments and outlined several interventions which included discussing behavioral issues with the interdisciplinary team (IDT), evaluating for possible causative factors if issues are identified, and, "Resident requires close observation." The care plan lacked further dictation on how R2 would be closely observed to ensure his or others safety.

R2's medical record, including progress notes, were reviewed and identified the following:

On 8/18/20, a progress note identified R2's ordered loxapine was reduced to 25 milligrams (mg) due to an abnormal ECG. There were orders to follow-up with the psychiatric nurse practitioner (NP)-A in one month.

On 10/1/20, a progress note identified R2 had refused his bath despite reproach. The note did not identify any other demonstrated behaviors by

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R2 despite refusing his bath.

On 10/15/20, a FOCUS progress note was recorded which listed, "Behaviors," as the reason for review. R2 was recorded as having schizophrenia and R2's loxapine reduction (from 8/18/20) was identified. R2 had moderate cognitive impairment and a section labeled, "Mood/Behavior," identified R2 as having anxiety and restlessness. However, the note lacked any further information on these listed behaviors, including how often the behaviors were happening, if at all, or specifics around any demonstrated episodes of them. Further, the note identified a section labeled, "Care plan interventions," which directed, "Notify MD [medical doctor] with any mood changes are observed, trauma informed approach observing and monitoring, provide opportunities for expression of feelings."

On 10/19/20, a progress note identified the pharmacy came to deliver R2's antipsychotic medication and draw routine laboratory work. R2 refused and threw his coffee at the employee. The note outlined, "Pharmacy unable to delivery [sic] medication since resident refused lab draw." The note identified registered nurse (RN)-A was updated.

On 10/22/20 (three days later), a progress note identified R2 had refused the laboratory draw on 10/19/20, and it was ordered they continue to re-approach R2 and attempt to obtain the lab(s) so R2's clozapine prescription could be filled.

A corresponding Genevive Progress Note, dated 10/22/20, identified R2's medical nurse practitioner (NP)-B was updated on R2's refusal

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to allow the laboratory draw on 10/19/20, so no medication was available for administration as a result. R2 was listed as consuming 500 mg of clozapine everyday. The note outlined NP-B responded, "Please call and tell [nursing home] to keep trying with labs. His psychiatrist is the ordering provider I believe."

On 10/23/20, a late-entry progress note was recorded which identified NP-B had been updated on R2's refusal to allow laboratory draw(s) for his clozapine. The note continued, "NP[-B] wanted nystrom appointment made ASAP [as soon as possible]. Nystrom [psychiatry clinic] appointment made for 11/12/20."

On 10/31/20, a progress note identified R2 came and sat by the 'West Desk.' R2 was questioned if he needed anything by the staff, but then " ... began yelling at writer to shut up. After a few minutes a [NA] came down the hallway and he looked at her and yelled 'you fucking nigger' X3 [three times]." R2 was recorded as spending "a good portion" of the day outside of his room walking around, including standing by the front door and pushing buttons in attempt to open it. The note lacked any evidence of interventions attempted by the staff to calm or redirect R2 despite these behaviors.

On 11/1/20, a progress note identified R2 was recorded as being, " ... very agitated, restless and having hallucinations during shift ... [nurse] waved at him and resident flicked nurse off, said 'fuck you' ... drew his arm back as if acting he was going to punch nurse." The note continued, "This is very abnormal behavior for resident." The nurse sat down next to R2 and talked with him which was effective in calming him down. The

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note identified the laboratory had attempted to draw R2's lab(s) on the prior shift which " ... is what caused resident to become upset." R2 was provided education on the importance of the lab draw, however, the note outlined R2 continued to be observed as restless but without physical aggression or agitation. The note continued, "[R2] approached nurse stating 'I am hearing voices.' Nurse asked what the voices were telling him and resident replied 'That no one likes me, everyone hates me, and that I should just die." The note identified the nurse provided comfort to R2 whom proceeded to hug the nurse and become upset and start crying. Genevive (physician service) was contacted due to R2's continued restlessness and an order for clonazepam 0.5 mg twice a day as-needed was provided for a three (3) day period " ... until cozapine issue was resolved." This was administered to R2 and the note recorded, " ... appeared to have effectiveness."

R2's corresponding Genevive Phone Encounter note, dated 10/31/20, identified the nursing home had contacted the service reporting R2 " ... is experiencing increased agitation, aggression and hallucinations ... patient was receiving Clozapine [sic], though a script has not been sent as they are waiting for lab work to be completed, though patient continues to refuse labs ... staff are concerned for his agitation." The note identified an order for clonazepam 0.5 mg twice a day as-needed for three days was provided along with, "Nursing staff are to follow-up with patient's PCP [primary care provider] this week regarding his agitation."

On 11/1/20, another progress note was recorded which identified R2 was " ... noted to be pacing

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around facility through out the morning. Per [night shift] report, resident was up all night pacing and did not sleep. Resident asking staff to purchase cigarettes for him. Yelling at staff 'I can smoke if I want! I'm over 18!' Emotional support and reassurance provided. Resident then approached staff member at front desk. Became upset with staff member when unable to get cigarettes and threw desk supplies across lobby." The note outlined education and encouragement was provided, however, R2 " ... Becomes more and more angry as staff re-approach." R2 was then provided time and space to express his feelings and " ... appeared to calm down but continues to refuse medications."

On 11/2/20, a progress note identified staff entered R2's room and R2 " ... had his pants off and was laying in bed. [R2] was masturbating." R2 proceeded to cover himself and the nurse provided R2 his oral pills when R2 then " ... put his right hand around the writers clavicle area then took his hand away and started to laugh." The note identified the nurse explained it was not appropriate to grab them in such a manner and left the room.

On 11/2/20, a subsequent progress note identified, "New behavior symptom noted. Behavior addressed with NP and guardian."

On 11/3/20, a progress note identified order(s) were received from NP-B to send R2 to the emergency room (ER). A subsequent note, dated 11/3/20, identified R2 had met with his guardian (G)-A and the nurse attempted to get the needed laboratory draw completed while she was present. The note recorded, " ... resident yelled 'Fuck you, you ain't taking any labs', then resident

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picked up an orange traffic cone and threw it at his guardian." NP-B was updated regarding the continued inability to draw the needed lab(s) and R2 " ... had been off his clozapine for almost two weeks, and that writer believed resident needed to be sent in to the hospital for further evaluation." R2 was sent to the hospital ER via ambulance.

R2's corresponding Genevive Progress Note, dated 11/3/20, identified NP-B was contacted as R2 had gone without his ordered clozapine for two weeks as he was refusing to allow laboratory draws. The note identified, "Behaviors increased [due to] not getting med." R2's guardian was present, and typically was able to get R2 to have labs drawn, so the nursing home staff were seeking an order for the needed lab draw(s). An addendum was dictated by NP-B which identified, "I [NP-B] don't manage this, his psych provider orders this ... Upon calling site nurse back, site nurses stated that orders for labs no longer needed, now need okay to send to ED ... [R2] threw a traffic cone at his guardian. Guardian states that she has never seen [R2] as agitated and aggressive as he is right now, wants sent into ED. Facility staff also aren't able to manage behaviors at this time." A telephone order was provided to send R2 to the ED.

R2's corresponding ED Provider Notes, dated 11/3/20, identified R2 presented to the ED with a chief complaint listed as, "Aggressive behavior." R2 reported he was homeless before then voicing he resided at the nursing home, and also was recorded as throwing a telephone at one of the nurses. R2 voiced he was unaware why he had been sent to the ED, but did endorse having suicidal ideation. R2's needed laboratory draw(s) were completed and a behavioral consultation

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was completed and cleared him for discharge back to the nursing home. R2 was recorded as, " ... he is now willing to go back on his medications." Further, R2's Behavioral Access progress note, dated 11/3/20, identified R2 reported not taking his medications as they made him feel "stressed out." R2 voiced he would return to the nursing home and " ... be on my best behavior and I'll take my medicine." R2 denied command hallucinations to hurt himself or others, but acknowledged having visual hallucinations at times. Further, R2's clinical status was listed which identified highly impulsive and aggressive behavior(s) towards others. R2 was cleared to return to the nursing home.

On 11/4/20, a progress note identified R2 returned from the ER and had several labs, including a urinalysis completed. The results were negative for a bladder infection and no new medication or treatment orders were provided. The note concluded, "He is to see [nurse practitioner] in 2 days."

On 11/4/20, a subsequent progress note identified the pharmacy had been updated on the completed laboratory draws, and R2 " ... needed his Clozapine [sic] medication as soon as possible." The pharmacist voiced they would contact the hospital to review the laboratory results and would contact the nursing home. The note concluded, "Writer is awaiting call back from pharmacy." Further, an additional note, dated 11/4/20, identified the pharmacy was again contacted. The pharmacist voiced they needed more information on how many days R2 had been without his clozapine; which the nursing home expressed had been "two weeks since his last administration ..." The pharmacist then

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expressed they needed to speak with the provider who prescribed the medication to see if it needed to be re-titrated given the length of time R2 had been off the medication. The pharmacist voiced a message had been left for the provider, and the note concluded, "Writer is awaiting a respond fro pharmacist ..."

On 11/6/20, at 1:38 a.m. a progress note identified R2 was seen coming out of his room at approximately 11:30 p.m. (on 11/5/20) and voiced he was going to get a soda. The note continued, " ... When he didn't come back in 15 minutes ... asked CNA to go se if he was still by pop machine but CNA couldn't find him. Writer, nurse from east [sic] and 2 CNA's split up to check all rooms and other areas of the building ... [NA-A] found him raping a female resident and screamed for help. The 2 male CNA's pulled him off her and walked him back to his room. The DON [director of nursing] and charge RN were called. The police were called and the police took him about [1:30 a.m.]. For more details see VA [vulnerable adult] report."

R2's Medication Administration Record (MAR), dated 10/2020 to 11/2020, identified R2's physician ordered medications and their subsequent administration record(s). An order was listed for clozapine 500 milligrams (mg) everyday; which had a listed start date of 6/25/20. The medication was record as being given and consumed by R2 until 10/20/20. From 10/21/20 to 11/5/20, the MAR identified nearly all subsequent doses of the medication were not given with numerous entries of, "18," which was identified via legend as, "Med not available from pharmacy."

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R2's Documentation Survey Report, dated 9/2020 to 11/2020, was reviewed and identified R2's recorded behaviors using a legend and corresponding code system. The report demonstrated R2 had no recorded behaviors, including hitting, threatening, cursing at others or sexually inappropriate behaviors, in the month of September and October 2020. However, R2 had a single episode of sexually inappropriate behavior recorded on 11/2/20 which was outlined as, "disrupted [the] environment." R2 was re-directed but the intervention was ineffective. No other behaviors were recorded for R2 on these reports despite the repeated progress note(s) which identified him as cursing, throwing objects and wandering around the facility.

R2's medical record was reviewed and lacked evidence R2's escalating behaviors had been comprehensively assessed to help determine all contributing factors and subsequent interventions to help reduce and/or eliminate them despite the abrupt stopping of his prescribed antipsychotic medication. There was no evidence the facility had implemented any subsequent increased monitoring or supervision of R1 despite his antipsychotic medication being abruptly stopped and the ongoing documentation of escalating behaviors, including physically throwing items and being found masturbating in his room which had not been recorded or identified before 11/2/20 in his record.

When interviewed on 11/13/20, at 9:41 a.m. NA-A was interviewed and explained R2 was more independent with his needs and typically did not require much care from the staff. NA-A recalled the incident involving R2 and another resident being sexually assaulted and explained R2 had

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left his room on the night of 11/5/20, voicing he was going to walk down to the soda machine. R2 was gone for "about 15 minutes" when the nurse working (RN-B) had asked staff to start looking for R2 as he had "been acting weird the last few days" and had not yet returned yet. NA-A stated she opened a female resident's closed door and saw R2 on top of her in her bed with no pants or underwear on as he held her down and was "having sex with her." NA-A expressed R2's naked buttocks were visible immediately above her peri-area "moving up and down." NA-A stated she immediately yelled at R2 to "get off of her," but R2 just turned and looked at NA-A while he continued assaulting the female resident. NA-A voiced she yelled for help and male staff members then responded and removed R2 from the female residents bed and took him back to his room. NA-A explained the police were contacted and R2 was subsequently removed from the nursing home. Further, NA-A explained she had never known R2 to demonstrate sexual behaviors prior, but verified he was not on any formal supervision or monitoring despite being identified as 'acting weird' the past few days.

During interview on 11/13/20, at 10:20 a.m. RN-B described R2 as someone who "didn't need much care" and would often walk around the nursing home at night adding R2 was not known to enter other resident' rooms to her knowledge. RN-B verified R2 was found in a female resident's room on 11/5/20, and had sexually assaulted her which resulted in the police being contacted. The police responded and interviewed R2 who, according to RN-B, then "admitted he had done it" and was then removed from the nursing home. RN-B recalled R2 never typically demonstrated any hallucinatory or aggressive behaviors which she

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could recall, however, voiced R2 had seemed to become "more restless" in the weeks leading up the 11/5/20 incident and R2's subsequent arrest and discharge from the nursing home. RN-B stated she was "not sure" why R2 had become more restless and expressed she "wasn't aware" there had been recorded notes outlining him as being aggressive or masturbating prior to the incident on 11/5/20; however, had learned of the notes since he was arrested and removed from the nursing home.

On 11/13/20, at 1:07 p.m. registered nurse manager (RN)-A and licensed social worker (LSW)-A were interviewed. R2 admitted to the nursing home after a hospitalization and planned to discharge to a venue of less care when able to. They described R2 as "calm and responsive" and never really identified him to have behaviors prior to the weeks leading up to the incident on 11/5/20. LSW-A explained the facility typically reviewed a resident and their behaviors on a quarterly basis using "FOCUS meetings" along with a daily review completed through the stand-up meeting. They reviewed R2's FOCUS progress note (dated 10/15/20) and verified R2 displayed no hallucinations or aggressive behaviors at that time. They recalled "no major concerns" with him at the meeting adding they were actually unsure how they decided to record him as having restlessness and anxiety at that meeting. LSW-A stated the meetings were a newer process and they were still "trying to figure out" how to use them. RN-A explained R2 admitted using clozapine for his schizophrenia and consistently took the medication until 10/19/20, when he refused the routine laboratory monitoring and the pharmacist would not fill the prescription. RN-A explained the cart nurse then

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contacted R2's nurse practitioner (NP)-B a couple days later (on 10/22/20) who voiced she did not feel comfortable starting new medication or re-dosing the clozapine and directed an appointment with R2's psychiatry team should be made for as soon as possible. RN-A stated she then attempted to contact the psychiatric team via telephone, however, was unable to reach anyone so she left a message. A return call was never provided though and RN-A verified she never again attempted to contact the psychiatry provider as, at the time, she "didn't feel anybody was in immediate danger." They verified no increased supervision or monitoring had been placed on R2 despite abruptly stopping his antipsychotic medication; however, RN-A added such an intervention would be a good intervention to do for someone who abruptly ceased their medication. RN-A and LSW-A then reviewed R2's medical record and progress notes. They explained the behaviors being recorded after 10/19/20 were not normal behaviors R2 had demonstrated prior, and expressed no assessment or discussion of them had occurred at the daily stand-up meeting(s). RN-A voiced the floor nurses documenting the behaviors should be making sure the management team was aware of them and added they had "definitely not" been updated on these behaviors including the hallucinations, physical aggression and masturbation. They recalled the incident involving R2 sexually assaulting a female resident and reiterated they had not ever considered and assessed all the displayed behaviors R2 had since 10/19/20, including masturbation, when he abruptly stopped taking his antipsychotic medication. RN-A reiterated if they had been updated on the behaviors and known they were happening, they would have done some "more

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comprehensive assessment" of them and taken the situation "a little more seriously." LSW-A added she "didn't know the behaviors were escalating like that" and voiced she would have contacted the facility' psychiatry team (ACP) and tried to include them "if we [had been] aware of these crazy behaviors." RN-A and LSW-A verified no changes were made to R2's care plan, aside from a room change, from 10/19/20 until the incident involving R1 on 11/5/20 and added "maybe some education" was needed. Further, RN-A stated the behaviors not being forwarded to the management team was something "we need to address" in upcoming nurses meetings.

On 11/13/20, at 3:12 p.m. R2's medical nurse practitioner (NP)-B was interviewed. R2 was someone who was "very reserved" and "quiet" prior to 10/19/20, and NP-B verified she was "not aware of any behaviors" prior to the clozapine being abruptly stopped. NP-B explained she did not personally order or manage R2's clozapine as the prescriber is required to have a special certification as it was "a very dangerous medication." The medication required certain laboratory values to be checked periodically and, at times, pharmacies would not even release the medication until these lab(s) were obtained. As a result of those things, NP-B stated R2's psychiatry team was managing his ordered clozapine. NP-B explained when R2 refused the laboratory monitoring on 10/19/20, their on-call provider service was notified about it a couple days later on 10/22/20. NP-B voiced no new medication orders were given as she assumed the nursing home had already been in touch with R2's psychiatry team and she would have "no idea" what they ordered or did. On 10/31/20, NP-B stated they were again notified R2's

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behaviors seemed to be worsening and, at that time, a three (3) day dose of clonazepam (a medication used for anxiety) was provided. Then on 11/3/20, NP-B was updated again and told R2 was now being very aggressive and had gone for "two weeks" without his antipsychotic medication. NP-B stated this was the first time she realized he had not had his clozapine "for awhile" and then ordered him to be evaluated in the ED as the nursing home felt they couldn't control him anymore. The ED completed the necessary laboratory draw(s) and, to her knowledge, the nursing home was working on getting his clozapine restarted when he returned to the facility on 11/4/20. NP-B expressed she was not aware R2's psychiatry team had never been notified of his refusal to allow the laboratory draw(s) and subsequent holding of his clozapine voicing that was "unfortunate." Further, NP-B voiced if she had been told R2's psychiatry service had not been updated and R2 had started on clonazepam sooner, it may "potentially" have helped to calm and reduce R2's behaviors before he required treatment in the ED and subsequently sexually assaulted another resident.

On 11/13/20, at 3:37 p.m. the consulting pharmacist (CP) was interviewed and explained clozapine was a medication typically used when other antipsychotics had not worked due to it's potentially dangerous "side effects" and required special laboratory monitoring to ensure safety while the patient is on it. CP voiced it "probably wouldn't be a good idea" to abruptly stop the medication without slowly titrating down prior, and doing so could yield the sudden return of schizophrenia symptoms or other adverse effects. Further, CP stated she was unaware of the specifics regarding R2 and his missed

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clozapine medication; however, explained if he had stopped taking the medication abruptly and then had a return of symptoms that perhaps a different antipsychotic to help reduce or calm the symptoms may have helped. CP added the nursing home should have a policy on what to do when the patient refuses medications and how to address it.

On 11/17/20, at 11:32 a.m. the director of nursing (DON) was interviewed. The DON explained she received a telephone call shortly after midnight on 11/6/20, and the staff voiced "something terrible has happened" which they described as finding R2 "raping our poor [female resident]." The DON instructed them to contact the police department and then contacted and updated the administrator on the allegation. The DON voiced when she arrived at the nursing home, the police were present and voiced R2 was going to be arrested for "sexual misconduct" as R2 admitted to the police he committed the act. R2 was arrested and removed from the nursing home. The DON verified no formal supervision or safety checks were placed on R2 despite him abruptly stopping his antipsychotic medication and having documented escalating behaviors recorded in his progress notes. The DON stated masturbation, in itself, may or may not be considered behavioral as he could have been doing the act in private many times before; however, she did voice she had no knowledge of him being found doing it by staff throughout his stay prior to 11/2/20. The DON expressed R2 had no prior history of sexual behaviors to their knowledge and they were trying to find lesser care placement for him as he did not required skilled care. R2 did have a history of becoming upset with his roommate(s) though over various things like television volume, so they

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made the decision to move him to a private room just prior to the assault as R2 was "unpredictable" at times and would, at times, get aggressive when he was irritated. The DON explained she had heard about R2 not getting his scheduled clozapine when standing out by the nurses station and a nurse reported they did not have the medication to give. She could not recall the exact date she was first told R2 had not been getting his prescribed clozapine, but felt "pretty confident" she was not told until the week just prior to the sexual assault of the female resident. The DON voiced her expectation would have been to be informed the same day he initially refused the laboratory draw and subsequently had his medication not provided. The DON stated she then directed staff to ensure the guardian and NP-B were updated on the situation, and they attempted several times to draw the needed laboratory tests, but R2 would not allow it. The DON then reviewed R2's progress note(s) in his medical record verified there were "more behaviors documented" after 10/19/20, and added her expectation was for RN-A and LSW-A to review the progress notes "each day" and bring concerns, like escalating behaviors and missed medications, to the IDT meeting so they can be reviewed and addressed including reviewing for possible triggers, patterns and other issues. The DON verified R2's missed doses of clozapine were never raised at their IDT meetings and explained had the issues been presented at the meeting, she "would have intervened" and made sure appropriate action was taken adding RN-A and LSW-A were responsible to ensure the behaviors were assessed and "put all that together." The DON stated those assessments would have lead to multiple interventions which could have then been attempted to help ensure

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TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

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residents, including R2 himself, were kept safe and protected from his escalating behaviors.

A Sherburne County Inmate Locator, printed 11/17/20, identified R2 as a current inmate of the jail system with two charges listed. These charges included a misdemeanor charge for 5th degree assault; and, a felony charge of 3rd degree criminal sexual conduct. R2's custody date was recorded as 11/6/20, and no bail amount was posted.

During the abbreviated survey, from 11/13/20 to 11/18/20, multiple phone calls were attempted to interview NP-A regarding R2's behavior and the incident which happened on 11/5/20, where R2 was found in R1's room sexually assaulting her. A missed return call was provided on 11/18/20, and a message was left indicating a telephone interview would not be possible until 12/2/20. On 12/2/20, at 1:41 p.m. NP-A was interviewed and verified she helped oversee his psychiatric care for the duration of his nursing home admission. NP-A described R2 as a "very poor historian" who often displayed poor insight into his own mental health. NP-A recalled seeing R2 in person on 8/27/20, where a staff person was present and voiced R2 was doing well overall and having no concerning behaviors. NP-A stated their clinic was notified on 10/19/20, when R2 refused his laboratory draw and pharmacy would not fill his ordered clozapine; however, NP-A was on vacation at the time so she was not personally updated. NP-A stated the nursing home should have re-contacted them if no phone call was received back as someone stopping clozapine abruptly could demonstrate a return of their psychotic symptoms adding R2 appeared to have been off his clozapine for "about 15 days" when

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F 740	Continued From page 73 he was arrested. NP-A stated she was unaware of R2's escalating behaviors after 10/19/20, and voiced had their clinic been updated, they would have started other medications as "their were options available." NP-A expressed many antipsychotic medications, including clozapine, have side effects which can reduce sexual urge or desire and if they're abruptly stopped it could contribute to those desires returning, adding had R2 been medicated appropriately it may have "helped him to make better decisions" and potentially not sexually assault a female resident. A provided Behavior Management policy, dated 5/2017, identified a purpose of identifying residents who exhibit behaviors which decrease their physical and psychosocial well-being. The policy directed, "The interdisciplinary team [IDT] will address resident behaviors in the resident's comprehensive plan of care." A procedure was listed which directed the resident would be assessed upon admission, quarterly and upon a change in condition for factors which contribute to behaviors and the care plan would then be developed to reduce and/or eliminate the cause of behavioral symptoms. Further, the policy directed to reassess residents identified with behavioral symptoms at least quarterly or " ... more frequently" if deemed necessary by the IDT in the resident's medical record.	F 740		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		12/23/20

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F 880	Continued From page 74 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 75 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the failed to ensure staff followed environmental cleaning and disinfection procedures according to the disinfectant manufacturer's instructions to decrease the risk of infection transmission in the facility. This had the potential to affect all 57 residents residing in the facility. In addition, the facility failed to ensure staff correctly wore personal protective equipment (PPE) during daily room cleaning for 2 of 2 residents (R4 and R7) observed in droplet precautions and that staff performed hand hygiene while working in 4 of 4 resident (R4, R5, R6, and R7) rooms and during dining room meal service in the memory care unit. Lastly, the facility failed to ensure communal dining room guidance (maintenance of at least 6 feet between	F 880	" PERSONAL PROTECTIVE EQUIPMENT (PPE) o R4, R5, R6, R7 are no longer on droplet precautions. o All residents have the potential to be affected by staff not wearing PPE appropriately. Facility will identify any residents who require droplet precautions and designate appropriate signage in the doorway of their room and have adequate PPE available outside of the room with disposal containers available inside the room. o Staff education: nursing home staff educated on the importance of wearing PPE appropriately prior to entering a resident□s room for all departments	

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F 880	Continued From page 76 residents) was maintained for 11 of 12 residents (R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18) eating during meal service in the memory care unit. This had the potential to affect all 21 residents residing in the memory care unit at the time of the focused infection control survey. Findings include: ENVIRONMENTAL CLEANING/CHEMICAL USE/PPE USE A facility provided Daily Census report indicated R4 and R7 required 14 day admission quarantine droplet precautions. During observation on 11/18/20, at 9:14 a.m. the Westwood Lane had signs on two resident (R4, R7) doors that directed R4 and R7 were on droplet precautions, along with directions for personal protective equipment (PPE) use. Hand sanitizer was accessible on top of isolation bins located just outside of R4 and R7's doorways. On 11/18/20, during continued observation at 9:39 a.m. housekeeper (H)-A was observed to enter R4's room after donning PPE and performing hand hygiene. At 9:41 a.m. H-A exited R4's room with the same PPE on and carried a small trash can of used gowns and dumped contents of can into the housekeeping cart's uncovered garbage and returned the garbage can with the same liner back into R4's room. At that time, H-A's gown was untied and hung down from the front of the gown. At 9:43 a.m. the untied gown ties made multiple direct contacts with R4's floor as she bent over to clean R4's wheelchair. H-A exited the room, removed gown and gloves in the hallway, and disposed of them in the	F 880	including completion of competency. Staff are checked off on a staff roster to validate all applicable staff have completed the education and competency. o Residents and their representatives have education on the facility□s Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident□s capacity. o Policies for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care have been reviewed. o Policy for source control masks in place and reviewed. o Policy regarding standard and transmission-based precautions has been reviewed. o Audits: ¿ The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions, 3 x week x 1 month, then weekly x 1 months. ¿ The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits of source control for staff, visitors, and residents, on all shifts four times a week for one week, then twice weekly for x 3 weeks, then weekly x 1 months. ¿ The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to	

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F 880	Continued From page 77 housekeeping cart garbage. H-A did not perform hand hygiene. - At 9:45 a.m. H-A donned gloves, entered R6's room, and cleaned off the tray table and the furniture with a wet rag. H-A exited R6's room at 9:53 a.m., removed gloves, grabbed a roll of toilet paper from the cart, and brought the toilet paper to another resident's room a few doors down. H-A did not perform hand hygiene after glove removal. - At 9:54 a.m. H-A used non-gloved hands to grab both handles of a wheeled walker located outside of R7's room and moved it to the right side of R7's hallway isolation bin. H-A then moved a black basket of therapy supplies located on the wheeled walker's seat directly to the floor underneath the walker. At 9:55 a.m. H-A sprayed a solution on the walker and at 9:55 a.m. she used non-gloved hands to wipe the solution off with a dry cloth. H-A failed to perform hand hygiene after. Immediately after wiping off the walker, H-A stated the solution used was Sani-Clean 2. H-A explained the Sani-Clean 2 was sprayed on surfaces and left for "5 to 10 minutes" before being wiped dry. - At 9:56 a.m. H-A donned gloves without having performed hand hygiene and entered R7's room without having donned a gown. H-A grabbed a small garbage can of used gowns and dumped the contents of the garbage can into the housekeeping cart's uncovered garbage, which placed H-A in the middle of the hallway, and returned the can back into R7's room. At 9:57 a.m. H-A opened R7's bathroom door with her gloved hand, turned around when NA-E approached R7's doorway with a fresh water mug, and brought the mug to R7. H-A exited R7's room with the old mug and placed it on a top corner of the housekeeping cart. H-A touched multiple cloth mop heads located on top of the	F 880	ensure PPE is in use, 3 x week x 1 month, then weekly x 1 months. o Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation o Responsible for audits: Director of Nursing or designee o " EQUIPMENT/ENVIRONMENT o R4, R5, R6, R7 are no longer on droplet precautions. o All residents have the potential to be affected by staff not wearing PPE appropriately, not completing hand hygiene appropriately, and communal dining occurring within 6 feet of each other. Facility will identify any residents who require droplet precautions and designate appropriate signage in the doorway of their room and have adequate PPE available outside of the room with disposal containers available inside the room. o The director of housekeeping, director of maintenance, and director of nursing have reviewed policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time. o Staff education: staff responsible for resident care equipment and environment have been trained on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person has	

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F 880	Continued From page 78 cart with a gloved hand; however did not pick one up. Instead, she donned a new pair of gloves, failed to perform hand hygiene, and walked across the hall to R6's room and entered after having touched R6's room door handle. H-A exited R6's room with a spray can of glass cleaner and entered R7's bathroom. At 9:59 a.m. H-A cleaned R6's toilet without allowing the chemical to sit prior to flushing, and touched multiple clean dry cleaning rags on the cart with gloved hands once she exited the room. H-A wiped down most things in the bathroom with a wet rag; however, failed to wipe down the sink. Again, H-A touched multiple things located on the cart with her gloved hands and again entered R7's bathroom, cleaned the mirror with a designated glass cleaner, and then used the same glass cleaner to clean out the sink. At 10:01 a.m. H-A touched a stack of clean rag and cloth mop heads on the cart with gloved hands and used a new wet rag to clean off the light in the bathroom. At 10:02 a.m. NA-E approached H-A and questioned her on lack of gown use. H-A acknowledged NA-E; however, had finished cleaning in R7's room and did not don a gown at that time. Immediately after NA-E approached H-A, H-A removed her gloves, failed to perform hand hygiene, and handed R7's old water mug to NA-E. H-A failed to perform hand hygiene after she touched R7's mug. - At 10:04 a.m. H-A donned gloves, entered R5's room and sprayed an instant action foaming cleaner onto R5's wheelchair which she wiped off right away after applying. On 11/18/20, at 10:18 a.m. during continued observation H-A housekeeper H-A was observed to exit R7's room after having washed the carpet with a carpet cleaner and proceeded down the	F 880	demonstrated competency at the conclusion of the training. Staff are checked off on a staff roster to validate all applicable staff have completed the education and competency. o Audits: ¿ The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning on all shifts every day for one week, 3x week x 3 weeks, then weekly x 1 month. o Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation o Responsible for audits: Director of Nursing or designee " HAND HYGIENE o R4, R5, R6, R7 are no longer on droplet precautions. o All residents have the potential to be affected by staff not completing hand hygiene appropriately. o The Infection Preventionist/Director of Nursing have reviewed hand hygiene policies and procedures to ensure they meet CDC guidance. o Staff education: training has been completed for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident□s rooms, whether it be for residents□ dietary needs or cleaning and maintenance services. The training covers standard infection control practices, including transmission-based precautions and adequately caring for and	

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F 880	Continued From page 79 hallway to a housekeeping room where she returned with more cleaner solution. H-A had a gown on and no gloves. The gown ties at H-A's waist were not tied which exposed the H-A's uniform back. H-A stepped a few feet into R5's room with the gown on, failed to perform hand hygiene, and prepped the cleaner for operation. At 10:21 a.m. H-A entered the room's main living section where R5 was seated in a recliner, about 2 feet from her wheelchair. H-A grabbed R5's wheelchair, brought it out into the hallway, and removed the gown as she started to walk down the hallway to the housekeeping cart located by the housekeeping room. H-A threw the gown in the cart's uncovered garbage at approximately 3 feet from the cart and returned to Westwood Lane. H-A failed to perform hand hygiene after gown removal. After being placed in the garbage, sections of the gown remained exposed above the top of the garbage and hung down over the end of the garbage can. - At 10:22 a.m. H-A entered R5's room and proceeded to touch the following items as she cleaned the carpet: R5's walker, tray table, bed foot board and covering, door edge, her uniform pockets. At 10:29 a.m. H-A finished cleaning the carpet, turned off the light by the doorway, and exited R5's room. H-A failed to perform hand hygiene after exiting R5's room. When interviewed on 11/18/20, at 10:29 a.m. H-A stated she was required to wear PPE when she entered a resident room designated with droplet precaution signage. H-A acknowledged she had not tied the gown correctly when she worked in R4 and R7's rooms and that she did not wear all the required PPE when in R7's room. Further, H-A acknowledged the numerous episodes of incorrect glove use and lack of hand hygiene	F 880	disinfecting shared medical equipment. o The Infection Preventionist, Director of Nursing/Clinical Education Coordinator, or designee have completed competency assessments for staff on proper hand hygiene. Staff are checked off on a staff roster to validate all applicable staff have completed the education and competency. o Audits: ¿ The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, 3x week x 3 weeks, then weekly x 1 month. o Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation o Responsible for audits: Director of Nursing or designee " SOCIAL DISTANCING CONCERNS o R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18 are no longer participating in communal dining unless they are at least 6 feet apart for meal service. o All residents who participate in communal dining or activities have the potential to be affected. o Nursing home staff educated on the importance of completing hand hygiene appropriately, and communal dining must occur at least 6 feet apart for residents. o Policies for social distancing among residents and staff, social distancing during dining/activities were reviewed. o Residents will be monitored for their	

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F 880	Continued From page 80 when she worked between R4, R5, R6, and R7's rooms, along with having worn the gown used in R4 and R7 out in the hallway. H-A stated the ties on the gowns did not "fit around me" and that she had not updated her supervisor about this. H-A voiced if the gown ties touched the floor there was a risk of "potentially contaminating things around" the room. H-A explained she had forgotten to put the gown on prior to entering R7's room and voiced she should have worn it; however, stated she did not think her incorrect actions impacted other residents as she was "just doing the bathroom and the floors." H-A voiced she was not aware of what the word droplet meant for droplet precautions. H-A stated she was expected to perform hand hygiene before entering and after exiting a resident room or before she touched items on her cart after she touched potentially contaminated items. Further, H-A explained she was expected to wear gloves when cleaning and she should remove the gloves also before touching items on her cart. In addition, H-A stated she was further expected to wear the gowns only inside a resident room and that the used gowns were not to be worn in the hallways. Additionally, H-A stated she should not have placed the gown haphazardly in the cart garbage as this should have been removed before she exited R7's room and disposed of correctly. H-A voiced she had never been told she was to tie the garbage bags in the residents room before exiting the room; however, did state this would be a good practice as "it could be contaminated." H-A explained she had used a Rest Stop toilet bowel cleaner to clean R7's toilet. H-A stated the manufacturer recommendation for use was to wait 10 minutes; however, H-A explained, "I do at least 5." H-A stated she used ZenaCrystal Glass Cleaner in R7's bathroom and	F 880	ability to understand or willingness to comply with social distancing and care plan interventions to promote compliance. Residents who are unable or unwilling to comply will be educated, re-educated, and redirected related to social distancing. o Staff education: all staff have been trained on the importance of social distancing of residents/staff/discontinuation of communal dining and activities. Staff are checked off on a staff roster to validate all applicable staff have completed the education and competency. Staff unavailable to complete education by compliance date will complete the education prior to working their next scheduled shift after the compliance date. o Audits: ¿ The Director of Nursing, the Infection Preventionist and other facility leadership will conduct rounds throughout the facility on each shift to ensure social distancing is being maintained by all staff and residents during various times of day and during various activities. The rounds will be conducted every day for four weeks, then weekly x 1 months. o Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation o Responsible for audits: Director of Nursing or designee	

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F 880	Continued From page 81	F 880		

she acknowledged using this on the sink. H-A explained glass cleaner was to only be used on glass surfaces and she should have used Sani-Clean 2 on the sink instead. H-A read the instructions for use of the Sani-Clean and verbalized it should remain on a surface wet for 10 minutes. H-A acknowledged incorrect use of the Sani-Clean on the therapy wheeled walker. In addition, H-A voiced she had not received training on the chemicals she was expected to use; however, she tries to keep things cleaned the best she can.

During interview on 11/18/20, at 11:05 a.m. housekeeping director (HD) stated Sani-Clean 2 was the main chemical used for cleaning in the facility, especially in resident bathrooms. HD explained the process when she used Sani-Clean 2 was to spray it on a surface, let it sit for two to three minutes, and then wipe it off "a little bit" so that it air dries; however, HD acknowledged the manufacturer instructions were for it to stay wet anywhere from 8 or 10 minutes. HD explained her staff could not leave it on the surfaces that long due to "people walking around." HD stated housekeeping also used an instant action foaming cleaner for other surfaces the Sani-Clean 2 was not used on. HD explained the directions for use were to keep on surfaces for about 2 minutes; however, when the can was examined, the instructions directed for staff to let sit for 10 minutes. HD explained her staff did not have that much time to let it sit on surfaces for that long. HD acknowledged staff were expected to follow the manufacturer instructions for use; however, explained due to work load and the number of housekeeping staff available, if staff followed the manufacture instructions for cleaning, they would not get all of their required

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	245438	A. BUILDING _____ B. WING _____	C 11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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cleaning work completed each day. HD denied having had conversations with the current administration about the cleaning instruction time frame concerns for the chemicals used in the facility. HD stated housekeeping staff were expected to wear all PPE as instructed, which should be removed inside the residents room and not worn outside the room. Further, HD explained she expected staff to wear gloves and perform hand hygiene as directed. In addition, HD stated she expected housekeeping staff to dispose of PPE as directed and to dispose of used PPE gowns by removing the bag from the trash can prior to placing the garbage bag in the cart trash. HD verbalized if staff did not follow infection control practices as directed she "would think that is a serious infection control issue as you have contaminated and exposed all those people to everything," and, "everyone could be sick." HD denied she has performed any recent audits as she "does not have the time" to do them or "follow up" on her staff. HD explained her staff had been trained on the Sani-Clean approximately five months ago; however, stated she does not document any training.

When interviewed on 11/18/20, at 2:08 p.m. the director of nursing (DON) stated housekeeping does all the cleaning; however, all staff were expected to follow the manufacturer instructions as the facility used a "variety" of cleaning products. Further, the DON explained all staff were expected to perform hand hygiene and to wear PPE as directed, that gowns were to be removed prior to exiting resident rooms identified on transmission based precautions, and that PPE was disposed of also as directed. The DON stated if staff were not following infection control guidelines there was a potential for them to

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TALAHI NURSING AND REHAB CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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"spread infection to residents and staff."

A Sani-Clean 2 manufacturer label, undated instructed staff for disinfecting and cleaning to, "Let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry."

A Rest Stop restroom disinfectant manufacturer information sheet, undated instructed staff when toilet bowls were cleaned to, "Allow product to remain on surface for a contact time of 10 minutes; then flush toilet."

A ZenaCrystal glass cleaner manufacturer information sheet, undated, indicated, "use to clean mirrors, windows, automotive glass, and other glass surfaces."

HAND HYGIENE

During a continued observation on 11/18/20, at 1:08 p.m. NA-D was seated at the corner of a dining room table feeding R8 and R9. At 1:11 p.m. NA-D fed R8 and R9 without using a designated hand for each resident. NA-D touched R9's hands as she assisted her to hold a glass of liquid. At 1:14 p.m. NA-D touched the divided plate of R9. At 1:16 p.m. NA-D wiped R8's face with a napkin using her right hand, picked up R9's silverware with her right hand, and started to feed R9. NA-D did not perform hand hygiene during these observations.

- At 1:18 p.m. NA-C entered the dining room carrying a resident room tray and placed it in a metal cart of other used meal trays. After, NA-C sat next to R8 and took over assisting R8 to eat. At 1:19 a.m. NA-C approached R10 and touched his wheelchair, silverware, and placed a cup in

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his hand. Immediately after, NA-C walked over to R11 and touched R11's head and fed her a bite of food. Immediately after, NA-C walked back to R8, touched her own hair as she sat down, and picked up R8's silverware. NA-C did not perform hand hygiene during these observations.

- At 1:21 p.m. NA-D touched her face mask with her right hand and then fed R9 using the same hand. At 1:24 a.m. NA-D walked over to R12 and handed him a cup of coffee and removed his meal tray from the table. As she placed the meal tray in the metal container, she knocked over cups on the metal tray onto the floor. After NA-D picked up the cups, she walked R14 down to the day room where she handed R14 a cup of coffee and used the TV remote. R14 immediately drank from the cup. NA-D did not perform hand hygiene during these observations.

-At 1:28 p.m. NA-C, after picking up meal trays, handed R9 a glass which R9 immediately drank from. When R9 finished drinking, NA-C cleaned R9's mouth area with a clothing protector. NA-C brought the clothing protector to the designated laundry bin and touched the bin lid with bare hands to lift it. After, NA-C touched her own hair, took off another resident's clothing protector and placed the remaining trays in the metal cart. At 1:31 p.m. NA-C placed a transfer belt on R10 and transferred him to a recliner. NA-C did not perform hand hygiene during these observations.

During observation hand sanitizer was observed to be absent from the dining room tables. The only accessible sanitizer station was just inside the dining room, hanging on the wall which would have required staff to get up through out the meal to sanitize frequently.

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F 880	Continued From page 85 During interview on 11/18/20, at 1:34 p.m. NA-C stated hand hygiene was required before feeding residents and before and after touching them. NA-C acknowledged she did not perform hand hygiene during observation from 1:18 p.m. to prior to assisting R10 into the recliner. NA-C stated not performing hand hygiene at the required times risked getting the residents "sick." When interviewed on 11/18/20, at 1:40 p.m. NA-D stated hand hygiene was required before and after resident cares, before assisting a resident to eat, "before anything, " and, "after everything." NA-D acknowledged she had washed her hands prior to starting feeding assist in the dining room; however, denied having performed hand hygiene after that or throughout the remainder of the observation period. NA-C stated not performing hand hygiene at the required times risked, "definitely them getting sick or an infection." During interview on 11/28/20, at 2:08 p.m. the DON stated she would expect hand hygiene to be performed after any physical contact with a resident. The DON explained if staff were not following infection control guidelines there was a potential for them to "spread infection to residents and staff." COMMUNAL DINING: During observation on 11/18/20, at 1:08 p.m. 12 residents were seated around 6 tables in the memory care dining room. Each table was within six feet of at least one other adjacent table. All residents in the memory care dining room (R8,	F 880		

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R9, R10, R11, R12, R13, R14, R15, R16, R17, R18) except for R19 were observed to be approximately 3 feet from each other. R19 was the only resident observed to be socially distanced at 6 feet during meal time. The dining room floors or tables did not show visible indicators of placement reminders to ensure social distancing was maintained and there were no indicators to direct staff of resident placement.

On 11/28/20, at 1:18 p.m. NA-C was observed to enter the dining room and sat on the right side of R8, where NA-C was positioned across from NA-D and R9, and started to assist R8 with eating. NA-D continued to assist R9 with eating.

During interview on 11/18/20, at 1:34 p.m. NA-C stated knowledge of communal dining social distancing guidelines. NA-C explained residents typically sat in the same spot each meal; however, voiced with COVID-19 the staff try to spread the residents out. NA-C denied she attempted to place residents at different spots during the noon meal or encouraged them to spread out. NA-C acknowledged the residents were not socially distanced during the noon meal; however, explained she did not feel there was enough room to maintain social distancing for all residents eating in the dining room.

When interviewed on 11/18/20, at 1:40 p.m. NA-D stated knowledge of communal dining social distancing guidelines. NA-D explained, "We try our best to social distance but it is very hard." Further, NA-D explained the residents who required feeding assistance were the hardest residents to social distances as "we have to feed them at the same time" and "we do not always

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have three aides back here." NA-D acknowledged the residents were not socially distanced during the noon meal and denied she had attempted to place residents at different spots during the meal or encouraged them to spread out.

During interview on 11/18/20, at 1:50 p.m. registered nurse (RN)-C stated knowledge of communal dining social distancing guidelines. RN-C voiced he had entered the dining room around 12:30 p.m. that afternoon to observe for social distancing issues during the noon meal and stated he did not see concerns at that time. RN-C had not been able to recall which residents were present in the dining room or where they were seated during RN-C's observation. After RN-C had been verbally updated on the residents' seated pattern during the 1:08 p.m. observation, RN-C acknowledged all but one resident had not maintained social distancing during the meal.

On 11/28/20, surveyor's continued observational notes did not reflect RN-C entering the dining room from 1:08 p.m. to 1:33 p.m.

When interviewed on 11/28/20, at 2:08 p.m. the DON stated she expected staff to make sure social distancing of at least 6 feet was maintained during meals. The DON explained she had not observed the dining room during a meal "for some time" and had not been aware of issues regarding staff concerns in regards to social distancing. The DON stated staff have moved recliners and chairs in the memory care unit to help ensure social distancing in the lounge areas; however, she voiced that "things get moved around." The DON denies no specific actions

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have been taken to ensure social distancing in the dining room for meals; however, she stated, "We have talked about it." The DON explained if staff were not following infection control guidelines there was a potential for them to "spread infection to residents and staff."

A facility policy Personal Protective Equipment, revised 3/2/20 identified, "PPE includes gloves, masks, protective gowns, eye wear, and face shields." Further, the policy identified the following: "PPE is required for entry into isolation rooms and removal is required prior to leaving isolation rooms;" gloves should be worn when handling items that may be contaminated and when entering isolation areas; do not wear gloves in designated clean areas and remove before leaving a treatment area; immediately wash hands after removing gloves and glove use does not replace hand hygiene; gowns will be applied prior to entering treatment area and should not be worn in designated clean areas; gowns should be large enough to cover the clothing of the person using the gown and should be removed before leaving the treatment area. In addition, the policy directed when applying the gown all clothing is completely covered and be secured at the waist strings.

A facility policy Hand Hygiene, revised 9/17/20 instructed hand hygiene was to be performed before applying gloves or other PPE and after their removal, after potentially contaminated items were handled, and after contact with inanimate objects in the immediate vicinity of a resident.

A facility policy Cleaning and Disinfection of Resident Rooms or facility areas of

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F 880	Continued From page 89 Suspected/Confirmed COVID-19, dated 6/23/20 indicated staff were to follow the manufacturer's instructions for all cleaning and disinfection products for concentration, application method and contact time, etc. Further, the policy directed environmental services staff and others should clean hands often, including immediately after glove removal and that environmental services staff should wear disposable gloves and gowns for all task in the cleaning process, including handling trash. A facility COVID-19 policy, revised 10/19/20 identified, "Communal dining limited (for COVID-19 negative or asymptomatic residents only), residents may eat in the same room with social distancing. Limitations will be considered based on COVID-19 infections in the facility." Further, the policy identified, "Residents should remain 6 ft [feet] apart if in communal areas."	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 7, 2021

Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

Re: Reinspection Results
Event ID: 8TR512

Dear Administrator:

On December 31, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 31, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
December 11, 2020

Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

Re: State Nursing Home Licensing Orders
Event ID: 8TR511

Dear Administrator:

The above facility was surveyed on November 13, 2020 through November 18, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
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
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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: _____ B. WING _____	R-C 12/31/2020

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/31/20, an onsite revisit was conducted by surveyors of the Minnesota Department of Health (MDH) to follow up on correction orders issued for State Licensure from an abbreviated survey exited on 11/18/20. The complaint investigation(s) found substantiated at the time of the licensing survey were reviewed for compliance.	{2 000}		

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

Electronically Signed | 01/07/21

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{2 000}	Continued From page 1 H5438095C and all cited licensing orders were found to be corrected. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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TALAHI NURSING AND REHAB CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/13/20 to 11/18/20, a survey was conducted by surveyors from the Minnesota Department of Health (MDH) to determine compliance for state licensure in conjuction with complaint investigation(s): H5438095C As a result, the following correction orders are	2 000		

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2 000	Continued From page 1 issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to coordinate care and obtain physician orders and/or guidance from an outside psychiatric physician group to ensure mental health needs were addressed for 1 of 1 residents (R2) reviewed who refused laboratory monitoring and subsequently had their ordered antipsychotic medications held for an extended period of time. Findings include: R2's quarterly MDS, dated 9/29/20, identified R2 had schizophrenia (a disorder which affects a	2 830	Corrected	12/23/20

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2 830	Continued From page 3	2 830		

person's ability to think, feel, and behave clearly) and moderate cognitive impairment. Further, R2 demonstrated no hallucinations, delusions or rejection of care behaviors, and required only supervision with ambulation in the corridor and his room.

R2's care plan, dated 10/5/20, identified R2 had a communication deficit and directed staff to, "Anticipate and meet needs." Further, R2 was identified to consume antipsychotic medication and listed a goal of being free of psychotropic medication related complications. The care plan listed several interventions to help R2 meet this goal including, but not limited to, administering the medication(s) as ordered, consulting with the pharmacist and physician on potential dose reductions, and monitoring for adverse side effects including agitation and restlessness.

R2's medical record, including progress notes, were reviewed and identified the following:

On 10/19/20, a progress note identified the pharmacy came to deliver R2's antipsychotic medication and draw routine laboratory work. R2 refused and threw his coffee at the employee. The note outlined, "Pharmacy unable to delivery [sic] medication since resident refused lab draw." The note identified registered nurse (RN)-A was updated.

On 10/22/20 (three days later), a progress note identified R2 had refused the laboratory draw on 10/19/20, and it was ordered they continue to re-approach R2 and attempt to obtain the lab(s) so R2's clozapine prescription could be filled. A corresponding Genevive (Physician Group) Progress Note, dated 10/22/20, identified R2's medical nurse practitioner (NP)-B was updated

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2 830	Continued From page 4 on R2's refusal to allow the laboratory draw on 10/19/20, so no medication was available for administration as a result. R2 was listed as consuming 500 mg of clozapine everyday. The note outlined NP-B responded, "Please call and tell [nursing home] to keep trying with labs. His psychiatrist is the ordering provider I believe." On 10/23/20, a late-entry progress note was recorded which identified NP-B had been updated on R2's refusal to allow laboratory draw(s) for his clozapine. The note continued, "NP[-B] wanted nystrom appointment made ASAP [as soon as possible]. Nystrom [psychiatry clinic] appointment made for 11/12/20." On 10/31/20, a progress note identified R2 came and sat by the 'West Desk.' R2 was questioned if he needed anything by the staff, but then " ... began yelling at writer to shut up. After a few minutes a [NA] came down the hallway and he looked at her and yelled 'you fucking nigger' X3 [three times]." R2 was recorded as spending "a good portion" of the day outside of his room walking around, including standing by the front door and pushing buttons in attempt to open it. The note lacked any evidence of interventions attempted by the staff to calm or redirect R2 despite these behaviors. On 11/1/20, a progress note identified R2 was recorded as being, " ... very agitated, restless and having hallucinations during shift ... [nurse] waved at him and resident flicked nurse off, said 'fuck you' ... drew his arm back as if acting he was going to punch nurse." The note continued, "This is very abnormal behavior for resident." The nurse sat down next to R2 and talked with him which was effective in calming him down. The note identified the laboratory had attempted to	2 830		

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2 830	Continued From page 5 draw R2's lab(s) on the prior shift which " ... is what caused resident to become upset." R2 was provided education on the importance of the lab draw, however, the note outlined R2 continued to be observed as restless but without physical aggression or agitation. The note continued, "[R2] approached nurse stating 'I am hearing voices.' Nurse asked what the voices were telling him and resident replied 'That no one likes me, everyone hates me, and that I should just die." The note identified the nurse provided comfort to R2 whom proceeded to hug the nurse and become upset and start crying. Genevive (physician service) was contacted due to R2's continued restlessness and an order for clonazepam 0.5 mg twice a day as-needed was provided for a three (3) day period " ... until cozapine issue was resolved." This was administered to R2 and the note recorded, " ... appeared to have effectiveness." R2's corresponding Genevive Phone Encounter note, dated 10/31/20, identified the nursing home had contacted the service reporting R2 " ... is experiencing increased agitation, aggression and hallucinations ... patient was receiving Clozapine [sic], though a script has not been sent as they are waiting for lab work to be completed, though patient continues to refuse labs ... staff are concerned for his agitation." The note identified an order for clonazepam 0.5 mg twice a day as-needed for three days was provided along with, "Nursing staff are to follow-up with patient's PCP [primary care provider] this week regarding his agitation." On 11/1/20, another progress note was recorded which identified R2 was " ... noted to be pacing around facility through out the morning. Per [night shift] report, resident was up all night pacing and did not sleep. Resident asking staff to purchase cigarettes for him. Yelling at staff 'I can smoke if I	2 830		

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2 830	Continued From page 6 want! I'm over 18!' Emotional support and reassurance provided. Resident then approached staff member at front desk. Became upset with staff member when unable to get cigarettes and threw desk supplies across lobby." The note outlined education and encouragement was provided, however, R2 " ... Becomes more and more angry as staff re-approach." R2 was then provided time and space to express his feelings and " ... appeared to calm down but continues to refuse medications." On 11/2/20, a progress note identified staff entered R2's room and R2 " ... had his pants off and was laying in bed. [R2] was masturbating." R2 proceeded to cover himself and the nurse provided R2 his oral pills when R2 then " ... put his right hand around the writers clavicle area then took his hand away and started to laugh." The note identified the nurse explained it was not appropriate to grab them in such a manner and left the room. On 11/2/20, a subsequent progress note identified, "New behavior symptom noted. Behavior addressed with NP and guardian." On 11/3/20, a progress note identified order(s) were received from NP-B to send R2 to the emergency room (ER). A subsequent note, dated 11/3/20, identified R2 had met with his guardian (G)-A and the nurse attempted to get the needed laboratory draw completed while she was present. The note recorded, " ... resident yelled 'Fuck you, you ain't taking any labs', then resident picked up an orange traffic cone and threw it at his guardian." NP-B was updated regarding the continued inability to draw the needed lab(s) and R2 " ... had been off his clozapine for almost two weeks, and that writer believed resident needed	2 830		

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to be sent in to the hospital for further evaluation." R2 was sent to the hospital ER via ambulance. R2's corresponding Genevive Progress Note, dated 11/3/20, identified NP-B was contacted as R2 had gone without his ordered clozapine for two weeks as he was refusing to allow laboratory draws. The note identified, "Behaviors increased [due to] not getting med." R2's guardian was present, and typically was able to get R2 to have labs drawn, so the nursing home staff were seeking an order for the needed lab draw(s). An addendum was dictated by NP-B which identified, "I [NP-B] don't manage this, his psych provider orders this ... Upon calling site nurse back, site nurses stated that orders for labs no longer needed, now need okay to send to ED ... [R2] threw a traffic cone at his guardian. Guardian states that she has never seen [R2] as agitated and aggressive as he is right now, wants sent into ED. Facility staff also aren't able to manage behaviors at this time." A telephone order was provided to send R2 to the ED.

R2's ED Provider Notes, dated 11/3/20, identified R2 presented to the ED with a chief complaint listed as, "Aggressive behavior." R2 reported he was homeless before then voicing he resided at the nursing home, and also was recorded as throwing a telephone at one of the nurses. R2 voiced he was unaware why he had been sent to the ED, but did endorse having suicidal ideation. R2's needed laboratory draw(s) were completed and a behavioral consultation was completed and cleared him for discharge back to the nursing home. R2 was recorded as, " ... he is now willing to go back on his medications." Further, R2's Behavioral Access progress note, dated 11/3/20, identified R2 reported not taking his medications as they made him feel "stressed out." R2 voiced he would return to the nursing home and " ... be

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2 830	Continued From page 8 on my best behavior and I'll take my medicine." R2 denied command hallucinations to hurt himself or others, but acknowledged having visual hallucinations at times. Further, R2's clinical status was listed which identified highly impulsive and aggressive behavior(s) towards others. R2 was cleared to return to the nursing home. On 11/4/20, a progress note identified R2 returned from the ER and had several labs, including a urinalysis completed. The results were negative for a bladder infection and no new medication or treatment orders were provided. The note concluded, "He is to see [nurse practitioner] in 2 days." On 11/4/20, a subsequent progress note identified the pharmacy had been updated on the completed laboratory draws, and R2 " ... needed his Clozapine [sic] medication as soon as possible." The pharmacist voiced they would contact the hospital to review the laboratory results and would contact the nursing home. The note concluded, "Writer is awaiting call back from pharmacy." Further, an additional note, dated 11/4/20, identified the pharmacy was again contacted. The pharmacist voiced they needed more information on how many days R2 had been without his clozapine; which the nursing home expressed had been "two weeks since his last administration ..." The pharmacist then expressed they needed to speak with the provider who prescribed the medication to see if it needed to be re-titrated given the length of time R2 had been off the medication. The pharmacist voiced a message had been left for the provider, and the note concluded, "Writer is awaiting a respond fro pharmacist ..." On 11/6/20, at 1:38 a.m. a progress note	2 830		

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2 830	Continued From page 9 identified R2 sexually assaulted a female resident and was removed from the facility by the police. R2's Medication Administration Record (MAR), dated 10/2020 to 11/2020, identified R2's physician ordered medications and their subsequent administration record(s). An order was listed for clozapine 500 milligrams (mg) everyday; which had a listed start date of 6/25/20. The medication was record as being given and consumed by R2 until 10/20/20. From 10/21/20 to 11/5/20, the MAR identified nearly all subsequent doses of the medication were not given with numerous entries of, "18," which was identified via legend as, "Med not available from pharmacy." R2's medical record was reviewed and lacked evidence R2 escalating behaviors were communicated to R2's psychiatry team for new physician orders or direction despite him refusing the laboratory draw and subsequently having his prescribed antipsychotic medication held since 10/20/20. On 11/13/20, at 1:07 p.m. registered nurse manager (RN)-A and licensed social worker (LSW)-A were interviewed. R2 admitted to the nursing home after a hospitalization and planned to discharge to a venue of less care when able to. They described R2 as "calm and responsive" and never really identified him to have behaviors prior to the weeks leading up to the incident involving a female resident on 11/5/20. RN-A explained R2 admitted using clozapine for his schizophrenia and consistently took the medication until 10/19/20, when he refused the routine laboratory monitoring and the pharmacist would not fill the prescription. RN-A explained the cart nurse then contacted R2's nurse practitioner (NP)-B a couple	2 830		

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days later (on 10/22/20) who voiced she did not feel comfortable starting new medication or re-dosing the clozapine and directed an appointment with R2's psychiatry team should be made for as soon as possible. RN-A stated she then attempted to contact the psychiatric team via telephone, however, was unable to reach anyone so she left a message. A return call was never provided though and RN-A verified she never again attempted to contact the psychiatry provider as, at the time, she "didn't feel anybody was in immediate danger."

On 11/13/20, at 3:12 p.m. R2's medical nurse practitioner (NP)-B was interviewed. R2 was someone who was "very reserved" and "quiet" prior to 10/19/20, and NP-B verified she was "not aware of any behaviors" prior to the clozapine being abruptly stopped. NP-B explained she did not personally order or manage R2's clozapine as the prescriber is required to have a special certification as it was "a very dangerous medication." The medication required certain laboratory values to be checked periodically and, at times, pharmacies would not even release the medication until these lab(s) were obtained. As a result of those things, NP-B stated R2's psychiatry team was managing his ordered clozapine. NP-B explained when R2 refused the laboratory monitoring on 10/19/20, their on-call provider service was notified about it a couple days later on 10/22/20. NP-B voiced no new medication orders were given as she assumed the nursing home had already been in touch with R2's psychiatry team and she would have "no idea" what they ordered or did. On 10/31/20, NP-B stated they were again notified R2's behaviors seemed to be worsening and, at that time, a three (3) day dose of clonazepam (a medication used for anxiety) was provided. Then

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on 11/3/20, NP-B was updated again and told R2 was now being very aggressive and had gone for "two weeks" without his antipsychotic medication. NP-B stated this was the first time she realized he had not had his clozapine "for awhile" and then ordered him to be evaluated in the ED as the nursing home felt they couldn't control him anymore. The ED completed the necessary laboratory draw(s) and, to her knowledge, the nursing home was working on getting his clozapine restarted when he returned to the facility on 11/4/20. NP-B expressed she was not aware R2's psychiatry team had never been notified of his refusal to allow the laboratory draw(s) and subsequent holding of his clozapine voicing that was "unfortunate."

When interviewed on 11/17/20, at 11:32 a.m. the director of nursing (DON) explained she had heard about R2 not getting his scheduled clozapine when standing out by the nurses station and a nurse reported they did not have the medication to give. She could not recall the exact date she was first told R2 had not been getting his prescribed clozapine, but felt "pretty confident" she was not told until the week just prior to the sexual assault of the female resident on 11/5/20. The DON voiced her expectation would have been to be informed the same day he initially refused the laboratory draw and subsequently had his medication not provided.

During the abbreviated survey, from 11/13/20 to 11/18/20, multiple phone calls were attempted to interview NP-A regarding R2's behavior and the incident which happened on 11/5/20, where R2 was found in R1's room sexually assaulting her. A missed return call was provided on 11/18/20, and a message was left indicating a telephone interview would not be possible until 12/2/20. On

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2 830	Continued From page 12 12/2/20, at 1:41 p.m. NP-A was interviewed and verified she helped oversee his psychiatric care for the duration of his nursing home admission. NP-A described R2 as a "very poor historian" who often displayed poor insight into his own mental health. NP-A stated their clinic was notified on 10/19/20, when R2 refused his laboratory draw and pharmacy would not fill his ordered clozapine; however, NP-A was on vacation at the time so she was not personally updated. NP-A stated the nursing home should have re-contacted them if no phone call was received back as someone stopping clozapine abruptly could demonstrate a return of their psychotic symptoms adding R2 appeared to have been off his clozapine for "about 15 days" when he was arrested. NP-A stated she was unaware of R2's escalating behaviors after 10/19/20, and voiced had their clinic been updated, they would have started other medications as "their were options available." A provided Physician Services policy, dated 3/27/20, identified each resident must remain under the care of a physician while admitted to the nursing home. Further, the policy directed a resident's attending physician was responsible to prescribing new therapy, however, they could delegate task(s) to the nurse practitioners, as desired. The policy lacked any direction or guidance on coordination of physician care with outside providers when the attending staff are unable to prescribe needed therapies or medications. Based on interview and document review, the facility failed to ensure escalating behaviors were appropriately assessed and interventions implemented to ensure safety and reduce the risk	2 830		

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2 830	Continued From page 13 of adverse events for 1 of 1 residents (R2) reviewed who demonstrated increased physical aggression and hallucinations after abruptly stopping their antipsychotic medication. This resulted in actual psychosocial harm for R2 when the lack of assessment and interventions contributed to escalating behaviors and the sexual assault of another resident resulting in R2's imprisonment. Findings include: A submitted state agency (SA) Incident Report, dated 11/6/20, identified a facility' reported allegation of sexual abuse involving R2 sexually assaulting another resident. The report outlined R2 had been found in the resident's room " ... having sexual intercourse." The report outlined the police were contacted and removed R2 from the facility. Further, the report listed several witnesses to the allegation which included nursing assistant (NA)-A, NA-B, licensed practical nurse (LPN)-A and registered nurse (RN)-B. On 11/13/20, at 12:22 p.m. R2's appointed guardian (G)-A was interviewed. G-A stated she had been involved in R2's care for over the past year and explained R2 admitted to the nursing home in June 2020 for some rehabilitation therapy after a hospitalization. G-A described R2's mentation as "stable until he went off his meds" and outlined she felt he was doing "quite well" before 10/19/20, when his prescribed clozapine (an antipsychotic medication) was stopped abruptly. G-A expressed R2 had refused his laboratory draw which is what led him to not be provided his ordered antipsychotic medication and subsequently have worsening behaviors. G-A voiced she had never known or seen R2 to act with the demonstrated behaviors he had in the	2 830		

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2 830	Continued From page 14 weeks prior to his arrest and subsequent discharge from the nursing home. G-A then recalled the events which led up to 11/6/20 and him sexually assaulting another resident. G-A was aware R2 had been found masturbating in his room on 11/2/20, and then expressed the facility had contacted her regarding moving R2 to a different room as he had previously been witnessed standing in the doorway of another resident's room and "making inappropriate sexual comments." However, the facility never provided the documentation to her of him doing that as it had just been expressed verbally to her by a staff member whom she could not recall. G-A stated she was not notified timely of R2 refusing the laboratory draw, nor the subsequent holding of his antipsychotic medications, which was frustrating to her as the nursing home should have contacted her and he could have been hospitalized or treated sooner before sexually assaulting someone. Further, G-A stated R2 was currently locked in jail with multiple charges pending against him from the sexual assault which made her upset as she believed the entire escalation of R2's behaviors and subsequent sexual assault on another resident could have been prevented if the facility had responded appropriately. G-A reiterated, "I believe this could have been prevented!" R2's quarterly MDS, dated 9/29/20, identified R2 had schizophrenia (a disorder which affects a person's ability to think, feel, and behave clearly) and moderate cognitive impairment. Further, R2 demonstrated no hallucinations, delusions or rejection of care behaviors, and required only supervision with ambulation in the corridor and his room. R2's most recent Psychotropic Medication	2 830		

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2 830	Continued From page 15 Review and Evaluation, dated 9/22/20, identified R2 had schizophrenia and consumed several psychotropic medications including loxapine (an antipsychotic), clonazepam (used to reduce anxiety), and clozapine. The form listed a primary target behavior which read, "Hearing voices." This was listed as happening every two weeks. The assessment listed a radio-button style question which read, "Do these behaviors cause the resident to present a danger to themselves or others ... of interfere with the staff's ability to give care?" This was answered, "No." Further, the assessment identified R2's behaviors and management as, "Controlled." R2's care plan, dated 10/5/20, identified R2 had a communication deficit and directed staff to, "Anticipate and meet needs." R2 consumed antipsychotic medication and the care plan listed a goal of being free of psychotropic medication related complications with several interventions to help R2 meet this goal including, but not limited to, administering the medication(s) as ordered, consulting with the pharmacist and physician on potential dose reductions, and monitoring for adverse side effects including agitation and restlessness. Further, the care plan identified R2 was considered a vulnerable adult due to his cognitive impairments and outlined several interventions which included discussing behavioral issues with the interdisciplinary team (IDT), evaluating for possible causative factors if issues are identified, and, "Resident requires close observation." The care plan lacked further dictation on how R2 would be closely observed to ensure his or others safety. R2's medical record, including progress notes, were reviewed and identified the following:	2 830		

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2 830	Continued From page 16 On 8/18/20, a progress note identified R2's ordered loxapine was reduced to 25 milligrams (mg) due to an abnormal ECG. There were orders to follow-up with the psychiatric nurse practitioner (NP)-A in one month. On 10/1/20, a progress note identified R2 had refused his bath despite reproach. The note did not identify any other demonstrated behaviors by R2 despite refusing his bath. On 10/15/20, a FOCUS progress note was recorded which listed, "Behaviors," as the reason for review. R2 was recorded as having schizophrenia and R2's loxapine reduction (from 8/18/20) was identified. R2 had moderate cognitive impairment and a section labeled, "Mood/Behavior," identified R2 as having anxiety and restlessness. However, the note lacked any further information on these listed behaviors, including how often the behaviors were happening, if at all, or specifics around any demonstrated episodes of them. Further, the note identified a section labeled, "Care plan interventions," which directed, "Notify MD [medical doctor] with any mood changes are observed, trauma informed approach observing and monitoring, provide opportunities for expression of feelings." On 10/19/20, a progress note identified the pharmacy came to deliver R2's antipsychotic medication and draw routine laboratory work. R2 refused and threw his coffee at the employee. The note outlined, "Pharmacy unable to delivery [sic] medication since resident refused lab draw." The note identified registered nurse (RN)-A was updated. On 10/22/20 (three days later), a progress note	2 830		

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2 830	Continued From page 17 identified R2 had refused the laboratory draw on 10/19/20, and it was ordered they continue to re-approach R2 and attempt to obtain the lab(s) so R2's clozapine prescription could be filled. A corresponding Genevive Progress Note, dated 10/22/20, identified R2's medical nurse practitioner (NP)-B was updated on R2's refusal to allow the laboratory draw on 10/19/20, so no medication was available for administration as a result. R2 was listed as consuming 500 mg of clozapine everyday. The note outlined NP-B responded, "Please call and tell [nursing home] to keep trying with labs. His psychiatrist is the ordering provider I believe." On 10/23/20, a late-entry progress note was recorded which identified NP-B had been updated on R2's refusal to allow laboratory draw(s) for his clozapine. The note continued, "NP[-B] wanted nystrom appointment made ASAP [as soon as possible]. Nystrom [psychiatry clinic] appointment made for 11/12/20." On 10/31/20, a progress note identified R2 came and sat by the 'West Desk.' R2 was questioned if he needed anything by the staff, but then " ... began yelling at writer to shut up. After a few minutes a [NA] came down the hallway and he looked at her and yelled 'you fucking nigger' X3 [three times]." R2 was recorded as spending "a good portion" of the day outside of his room walking around, including standing by the front door and pushing buttons in attempt to open it. The note lacked any evidence of interventions attempted by the staff to calm or redirect R2 despite these behaviors. On 11/1/20, a progress note identified R2 was recorded as being, " ... very agitated, restless and	2 830		

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2 830	Continued From page 18	2 830		

having hallucinations during shift ... [nurse] waved at him and resident flicked nurse off, said 'fuck you' ... drew his arm back as if acting he was going to punch nurse." The note continued, "This is very abnormal behavior for resident." The nurse sat down next to R2 and talked with him which was effective in calming him down. The note identified the laboratory had attempted to draw R2's lab(s) on the prior shift which " ... is what caused resident to become upset." R2 was provided education on the importance of the lab draw, however, the note outlined R2 continued to be observed as restless but without physical aggression or agitation. The note continued, "[R2] approached nurse stating 'I am hearing voices.' Nurse asked what the voices were telling him and resident replied 'That no one likes me, everyone hates me, and that I should just die." The note identified the nurse provided comfort to R2 whom proceeded to hug the nurse and become upset and start crying. Genevive (physician service) was contacted due to R2's continued restlessness and an order for clonazepam 0.5 mg twice a day as-needed was provided for a three (3) day period " ... until cozapine issue was resolved." This was administered to R2 and the note recorded, " ... appeared to have effectiveness."

R2's corresponding Genevive Phone Encounter note, dated 10/31/20, identified the nursing home had contacted the service reporting R2 " ... is experiencing increased agitation, aggression and hallucinations ... patient was receiving Clozapine [sic], though a script has not been sent as they are waiting for lab work to be completed, though patient continues to refuse labs ... staff are concerned for his agitation." The note identified an order for clonazepam 0.5 mg twice a day as-needed for three days was provided along

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2 830	Continued From page 19	2 830		

with, "Nursing staff are to follow-up with patient's PCP [primary care provider] this week regarding his agitation."

On 11/1/20, another progress note was recorded which identified R2 was " ... noted to be pacing around facility through out the morning. Per [night shift] report, resident was up all night pacing and did not sleep. Resident asking staff to purchase cigarettes for him. Yelling at staff 'I can smoke if I want! I'm over 18!' Emotional support and reassurance provided. Resident then approached staff member at front desk. Became upset with staff member when unable to get cigarettes and threw desk supplies across lobby." The note outlined education and encouragement was provided, however, R2 " ... Becomes more and more angry as staff re-approach." R2 was then provided time and space to express his feelings and " ... appeared to calm down but continues to refuse medications."

On 11/2/20, a progress note identified staff entered R2's room and R2 " ... had his pants off and was laying in bed. [R2] was masturbating." R2 proceeded to cover himself and the nurse provided R2 his oral pills when R2 then " ... put his right hand around the writers clavicle area then took his hand away and started to laugh." The note identified the nurse explained it was not appropriate to grab them in such a manner and left the room.

On 11/2/20, a subsequent progress note identified, "New behavior symptom noted. Behavior addressed with NP and guardian."

On 11/3/20, a progress note identified order(s) were received from NP-B to send R2 to the emergency room (ER). A subsequent note, dated

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2 830	Continued From page 20 11/3/20, identified R2 had met with his guardian (G)-A and the nurse attempted to get the needed laboratory draw completed while she was present. The note recorded, " ... resident yelled 'Fuck you, you ain't taking any labs', then resident picked up an orange traffic cone and threw it at his guardian." NP-B was updated regarding the continued inability to draw the needed lab(s) and R2 " ... had been off his clozapine for almost two weeks, and that writer believed resident needed to be sent in to the hospital for further evaluation." R2 was sent to the hospital ER via ambulance. R2's corresponding Genevive Progress Note, dated 11/3/20, identified NP-B was contacted as R2 had gone without his ordered clozapine for two weeks as he was refusing to allow laboratory draws. The note identified, "Behaviors increased [due to] not getting med." R2's guardian was present, and typically was able to get R2 to have labs drawn, so the nursing home staff were seeking an order for the needed lab draw(s). An addendum was dictated by NP-B which identified, "I [NP-B] don't manage this, his psych provider orders this ... Upon calling site nurse back, site nurses stated that orders for labs no longer needed, now need okay to send to ED ... [R2] threw a traffic cone at his guardian. Guardian states that she has never seen [R2] as agitated and aggressive as he is right now, wants sent into ED. Facility staff also aren't able to manage behaviors at this time." A telephone order was provided to send R2 to the ED. R2's corresponding ED Provider Notes, dated 11/3/20, identified R2 presented to the ED with a chief complaint listed as, "Aggressive behavior." R2 reported he was homeless before then voicing he resided at the nursing home, and also was recorded as throwing a telephone at one of the	2 830		

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2 830	Continued From page 21	2 830		

nurses. R2 voiced he was unaware why he had been sent to the ED, but did endorse having suicidal ideation. R2's needed laboratory draw(s) were completed and a behavioral consultation was completed and cleared him for discharge back to the nursing home. R2 was recorded as, " ... he is now willing to go back on his medications." Further, R2's Behavioral Access progress note, dated 11/3/20, identified R2 reported not taking his medications as they made him feel "stressed out." R2 voiced he would return to the nursing home and " ... be on my best behavior and I'll take my medicine." R2 denied command hallucinations to hurt himself or others, but acknowledged having visual hallucinations at times. Further, R2's clinical status was listed which identified highly impulsive and aggressive behavior(s) towards others. R2 was cleared to return to the nursing home.

On 11/4/20, a progress note identified R2 returned from the ER and had several labs, including a urinalysis completed. The results were negative for a bladder infection and no new medication or treatment orders were provided. The note concluded, "He is to see [nurse practitioner] in 2 days."

On 11/4/20, a subsequent progress note identified the pharmacy had been updated on the completed laboratory draws, and R2 " ... needed his Clozapine [sic] medication as soon as possible." The pharmacist voiced they would contact the hospital to review the laboratory results and would contact the nursing home. The note concluded, "Writer is awaiting call back from pharmacy." Further, an additional note, dated 11/4/20, identified the pharmacy was again contacted. The pharmacist voiced they needed more information on how many days R2 had

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2 830	Continued From page 22 been without his clozapine; which the nursing home expressed had been "two weeks since his last administration ..." The pharmacist then expressed they needed to speak with the provider who prescribed the medication to see if it needed to be re-titrated given the length of time R2 had been off the medication. The pharmacist voiced a message had been left for the provider, and the note concluded, "Writer is awaiting a respond fro pharmacist ..." On 11/6/20, at 1:38 a.m. a progress note identified R2 was seen coming out of his room at approximately 11:30 p.m. (on 11/5/20) and voiced he was going to get a soda. The note continued, " ... When he didn't come back in 15 minutes ... asked CNA to go se if he was still by pop machine but CNA couldn't find him. Writer, nurse from east [sic] and 2 CNA's split up to check all rooms and other areas of the building ... [NA-A] found him raping a female resident and screamed for help. The 2 male CNA's pulled him off her and walked him back to his room. The DON [director of nursing] and charge RN were called. The police were called and the police took him about [1:30 a.m.]. For more details see VA [vulnerable adult] report." R2's Medication Administration Record (MAR), dated 10/2020 to 11/2020, identified R2's physician ordered medications and their subsequent administration record(s). An order was listed for clozapine 500 milligrams (mg) everyday; which had a listed start date of 6/25/20. The medication was record as being given and consumed by R2 until 10/20/20. From 10/21/20 to 11/5/20, the MAR identified nearly all subsequent doses of the medication were not given with numerous entries of, "18," which was identified via legend as, "Med not available from	2 830		

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2 830	Continued From page 23 pharmacy." R2's Documentation Survey Report, dated 9/2020 to 11/2020, was reviewed and identified R2's recorded behaviors using a legend and corresponding code system. The report demonstrated R2 had no recorded behaviors, including hitting, threatening, cursing at others or sexually inappropriate behaviors, in the month of September and October 2020. However, R2 had a single episode of sexually inappropriate behavior recorded on 11/2/20 which was outlined as, "disrupted [the] environment." R2 was re-directed but the intervention was ineffective. No other behaviors were recorded for R2 on these reports despite the repeated progress note(s) which identified him as cursing, throwing objects and wandering around the facility. R2's medical record was reviewed and lacked evidence R2's escalating behaviors had been comprehensively assessed to help determine all contributing factors and subsequent interventions to help reduce and/or eliminate them despite the abrupt stopping of his prescribed antipsychotic medication. There was no evidence the facility had implemented any subsequent increased monitoring or supervision of R1 despite his antipsychotic medication being abruptly stopped and the ongoing documentation of escalating behaviors, including physically throwing items and being found masturbating in his room which had not been recorded or identified before 11/2/20 in his record. When interviewed on 11/13/20, at 9:41 a.m. NA-A was interviewed and explained R2 was more independent with his needs and typically did not require much care from the staff. NA-A recalled the incident involving R2 and another resident	2 830		

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2 830	Continued From page 24 being sexually assaulted and explained R2 had left his room on the night of 11/5/20, voicing he was going to walk down to the soda machine. R2 was gone for "about 15 minutes" when the nurse working (RN-B) had asked staff to start looking for R2 as he had "been acting weird the last few days" and had not yet returned yet. NA-A stated she opened a female resident's closed door and saw R2 on top of her in her bed with no pants or underwear on as he held her down and was "having sex with her." NA-A expressed R2's naked buttocks were visible immediately above her peri-area "moving up and down." NA-A stated she immediately yelled at R2 to "get off of her," but R2 just turned and looked at NA-A while he continued assaulting the female resident. NA-A voiced she yelled for help and male staff members then responded and removed R2 from the female residents bed and took him back to his room. NA-A explained the police were contacted and R2 was subsequently removed from the nursing home. Further, NA-A explained she had never known R2 to demonstrate sexual behaviors prior, but verified he was not on any formal supervision or monitoring despite being identified as 'acting weird' the past few days. During interview on 11/13/20, at 10:20 a.m. RN-B described R2 as someone who "didn't need much care" and would often walk around the nursing home at night adding R2 was not known to enter other resident' rooms to her knowledge. RN-B verified R2 was found in a female resident's room on 11/5/20, and had sexually assaulted her which resulted in the police being contacted. The police responded and interviewed R2 who, according to RN-B, then "admitted he had done it" and was then removed from the nursing home. RN-B recalled R2 never typically demonstrated any hallucinatory or aggressive behaviors which she	2 830		

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2 830	Continued From page 25	2 830		

could recall, however, voiced R2 had seemed to become "more restless" in the weeks leading up the 11/5/20 incident and R2's subsequent arrest and discharge from the nursing home. RN-B stated she was "not sure" why R2 had become more restless and expressed she "wasn't aware" there had been recorded notes outlining him as being aggressive or masturbating prior to the incident on 11/5/20; however, had learned of the notes since he was arrested and removed from the nursing home.

On 11/13/20, at 1:07 p.m. registered nurse manager (RN)-A and licensed social worker (LSW)-A were interviewed. R2 admitted to the nursing home after a hospitalization and planned to discharge to a venue of less care when able to. They described R2 as "calm and responsive" and never really identified him to have behaviors prior to the weeks leading up to the incident on 11/5/20. LSW-A explained the facility typically reviewed a resident and their behaviors on a quarterly basis using "FOCUS meetings" along with a daily review completed through the stand-up meeting. They reviewed R2's FOCUS progress note (dated 10/15/20) and verified R2 displayed no hallucinations or aggressive behaviors at that time. They recalled "no major concerns" with him at the meeting adding they were actually unsure how they decided to record him as having restlessness and anxiety at that meeting. LSW-A stated the meetings were a newer process and they were still "trying to figure out" how to use them. RN-A explained R2 admitted using clozapine for his schizophrenia and consistently took the medication until 10/19/20, when he refused the routine laboratory monitoring and the pharmacist would not fill the prescription. RN-A explained the cart nurse then contacted R2's nurse practitioner (NP)-B a couple

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2 830	Continued From page 26 days later (on 10/22/20) who voiced she did not feel comfortable starting new medication or re-dosing the clozapine and directed an appointment with R2's psychiatry team should be made for as soon as possible. RN-A stated she then attempted to contact the psychiatric team via telephone, however, was unable to reach anyone so she left a message. A return call was never provided though and RN-A verified she never again attempted to contact the psychiatry provider as, at the time, she "didn't feel anybody was in immediate danger." They verified no increased supervision or monitoring had been placed on R2 despite abruptly stopping his antipsychotic medication; however, RN-A added such an intervention would be a good intervention to do for someone who abruptly ceased their medication. RN-A and LSW-A then reviewed R2's medical record and progress notes. They explained the behaviors being recorded after 10/19/20 were not normal behaviors R2 had demonstrated prior, and expressed no assessment or discussion of them had occurred at the daily stand-up meeting(s). RN-A voiced the floor nurses documenting the behaviors should be making sure the management team was aware of them and added they had "definitely not" been updated on these behaviors including the hallucinations, physical aggression and masturbation. They recalled the incident involving R2 sexually assaulting a female resident and reiterated they had not ever considered and assessed all the displayed behaviors R2 had since 10/19/20, including masturbation, when he abruptly stopped taking his antipsychotic medication. RN-A reiterated if they had been updated on the behaviors and known they were happening, they would have done some "more comprehensive assessment" of them and taken the situation "a little more seriously." LSW-A	2 830		

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2 830	Continued From page 27 added she "didn't know the behaviors were escalating like that" and voiced she would have contacted the facility' psychiatry team (ACP) and tried to include them "if we [had been] aware of these crazy behaviors." RN-A and LSW-A verified no changes were made to R2's care plan, aside from a room change, from 10/19/20 until the incident involving R1 on 11/5/20 and added "maybe some education" was needed. Further, RN-A stated the behaviors not being forwarded to the management team was something "we need to address" in upcoming nurses meetings. On 11/13/20, at 3:12 p.m. R2's medical nurse practitioner (NP)-B was interviewed. R2 was someone who was "very reserved" and "quiet" prior to 10/19/20, and NP-B verified she was "not aware of any behaviors" prior to the clozapine being abruptly stopped. NP-B explained she did not personally order or manage R2's clozapine as the prescriber is required to have a special certification as it was "a very dangerous medication." The medication required certain laboratory values to be checked periodically and, at times, pharmacies would not even release the medication until these lab(s) were obtained. As a result of those things, NP-B stated R2's psychiatry team was managing his ordered clozapine. NP-B explained when R2 refused the laboratory monitoring on 10/19/20, their on-call provider service was notified about it a couple days later on 10/22/20. NP-B voiced no new medication orders were given as she assumed the nursing home had already been in touch with R2's psychiatry team and she would have "no idea" what they ordered or did. On 10/31/20, NP-B stated they were again notified R2's behaviors seemed to be worsening and, at that time, a three (3) day dose of clonazepam (a medication used for anxiety) was provided. Then	2 830		

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2 830	Continued From page 28 on 11/3/20, NP-B was updated again and told R2 was now being very aggressive and had gone for "two weeks" without his antipsychotic medication. NP-B stated this was the first time she realized he had not had his clozapine "for awhile" and then ordered him to be evaluated in the ED as the nursing home felt they couldn't control him anymore. The ED completed the necessary laboratory draw(s) and, to her knowledge, the nursing home was working on getting his clozapine restarted when he returned to the facility on 11/4/20. NP-B expressed she was not aware R2's psychiatry team had never been notified of his refusal to allow the laboratory draw(s) and subsequent holding of his clozapine voicing that was "unfortunate." Further, NP-B voiced if she had been told R2's psychiatry service had not been updated and R2 had started on clonazepam sooner, it may "potentially" have helped to calm and reduce R2's behaviors before he required treatment in the ED and subsequently sexually assaulted another resident. On 11/13/20, at 3:37 p.m. the consulting pharmacist (CP) was interviewed and explained clozapine was a medication typically used when other antipsychotics had not worked due to it's potentially dangerous "side effects" and required special laboratory monitoring to ensure safety while the patient is on it. CP voiced it "probably wouldn't be a good idea" to abruptly stop the medication without slowly titrating down prior, and doing so could yield the sudden return of schizophrenia symptoms or other adverse effects. Further, CP stated she was unaware of the specifics regarding R2 and his missed clozapine medication; however, explained if he had stopped taking the medication abruptly and then had a return of symptoms that perhaps a different antipsychotic to help reduce or calm the	2 830		

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2 830	Continued From page 29 symptoms may have helped. CP added the nursing home should have a policy on what to do when the patient refuses medications and how to address it. On 11/17/20, at 11:32 a.m. the director of nursing (DON) was interviewed. The DON explained she received a telephone call shortly after midnight on 11/6/20, and the staff voiced "something terrible has happened" which they described as finding R2 "raping our poor [female resident]." The DON instructed them to contact the police department and then contacted and updated the administrator on the allegation. The DON voiced when she arrived at the nursing home, the police were present and voiced R2 was going to be arrested for "sexual misconduct" as R2 admitted to the police he committed the act. R2 was arrested and removed from the nursing home. The DON verified no formal supervision or safety checks were placed on R2 despite him abruptly stopping his antipsychotic medication and having documented escalating behaviors recorded in his progress notes. The DON stated masturbation, in itself, may or may not be considered behavioral as he could have been doing the act in private many times before; however, she did voice she had no knowledge of him being found doing it by staff throughout his stay prior to 11/2/20. The DON expressed R2 had no prior history of sexual behaviors to their knowledge and they were trying to find lesser care placement for him as he did not required skilled care. R2 did have a history of becoming upset with his roommate(s) though over various things like television volume, so they made the decision to move him to a private room just prior to the assault as R2 was "unpredictable" at times and would, at times, get aggressive when he was irritated. The DON explained she had heard about R2 not getting his scheduled	2 830		

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2 830	Continued From page 30 clozapine when standing out by the nurses station and a nurse reported they did not have the medication to give. She could not recall the exact date she was first told R2 had not been getting his prescribed clozapine, but felt "pretty confident" she was not told until the week just prior to the sexual assault of the female resident. The DON voiced her expectation would have been to be informed the same day he initially refused the laboratory draw and subsequently had his medication not provided. The DON stated she then directed staff to ensure the guardian and NP-B were updated on the situation, and they attempted several times to draw the needed laboratory tests, but R2 would not allow it. The DON then reviewed R2's progress note(s) in his medical record verified there were "more behaviors documented" after 10/19/20, and added her expectation was for RN-A and LSW-A to review the progress notes "each day" and bring concerns, like escalating behaviors and missed medications, to the IDT meeting so they can be reviewed and addressed including reviewing for possible triggers, patterns and other issues. The DON verified R2's missed doses of clozapine were never raised at their IDT meetings and explained had the issues been presented at the meeting, she "would have intervened" and made sure appropriate action was taken adding RN-A and LSW-A were responsible to ensure the behaviors were assessed and "put all that together." The DON stated those assessments would have lead to multiple interventions which could have then been attempted to help ensure residents, including R2 himself, were kept safe and protected from his escalating behaviors. A Sherburne County Inmate Locator, printed 11/17/20, identified R2 as a current inmate of the jail system with two charges listed. These	2 830		

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charges included a misdemeanor charge for 5th degree assault; and, a felony charge of 3rd degree criminal sexual conduct. R2's custody date was recorded as 11/6/20, and no bail amount was posted.

During the abbreviated survey, from 11/13/20 to 11/18/20, multiple phone calls were attempted to interview NP-A regarding R2's behavior and the incident which happened on 11/5/20, where R2 was found in R1's room sexually assaulting her. A missed return call was provided on 11/18/20, and a message was left indicating a telephone interview would not be possible until 12/2/20. On 12/2/20, at 1:41 p.m. NP-A was interviewed and verified she helped oversee his psychiatric care for the duration of his nursing home admission. NP-A described R2 as a "very poor historian" who often displayed poor insight into his own mental health. NP-A recalled seeing R2 in person on 8/27/20, where a staff person was present and voiced R2 was doing well overall and having no concerning behaviors. NP-A stated their clinic was notified on 10/19/20, when R2 refused his laboratory draw and pharmacy would not fill his ordered clozapine; however, NP-A was on vacation at the time so she was not personally updated. NP-A stated the nursing home should have re-contacted them if no phone call was received back as someone stopping clozapine abruptly could demonstrate a return of their psychotic symptoms adding R2 appeared to have been off his clozapine for "about 15 days" when he was arrested. NP-A stated she was unaware of R2's escalating behaviors after 10/19/20, and voiced had their clinic been updated, they would have started other medications as "their were options available." NP-A expressed many antipsychotic medications, including clozapine, have side effects which can reduce sexual urge

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2 830	Continued From page 32 or desire and if they're abruptly stopped it could contribute to those desires returning, adding had R2 been medicated appropriately it may have "helped him to make better decisions" and potentially not sexually assault a female resident. A provided Behavior Management policy, dated 5/2017, identified a purpose of identifying residents who exhibit behaviors which decrease their physical and psychosocial well-being. The policy directed, "The interdisciplinary team [IDT] will address resident behaviors in the resident's comprehensive plan of care." A procedure was listed which directed the resident would be assessed upon admission, quarterly and upon a change in condition for factors which contribute to behaviors and the care plan would then be developed to reduce and/or eliminate the cause of behavioral symptoms. Further, the policy directed to reassess residents identified with behavioral symptoms at least quarterly or " ... more frequently" if deemed necessary by the IDT in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on behavioral assessment and care planning, then inservice staff to ensure the timely assessment of worsening behaviors; then audit resident charts to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection	21375		12/23/20

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21375	Continued From page 33 control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the failed to ensure staff followed environmental cleaning and disinfection procedures according to the disinfectant manufacturer's instructions to decrease the risk of infection transmission in the facility. This had the potential to affect all 57 residents residing in the facility. In addition, the facility failed to ensure staff correctly wore personal protective equipment (PPE) during daily room cleaning for 2 of 2 residents (R4 and R7) observed in droplet precautions and that staff performed hand hygiene while working in 4 of 4 resident (R4, R5, R6, and R7) rooms and during dining room meal service in the memory care unit. Lastly, the facility failed to ensure communal dining room guidance (maintenance of at least 6 feet between residents) was maintained for 11 of 12 residents (R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18) eating during meal service in the memory care unit. This had the potential to affect all 21 residents residing in the memory care unit at the time of the focused infection control survey. Findings include: ENVIRONMENTAL CLEANING/CHEMICAL USE/PPE USE A facility provided Daily Census report indicated R4 and R7 required 14 day admission quarantine droplet precautions. During observation on 11/18/20, at 9:14 a.m. the	21375	Corrected	

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Westwood Lane had signs on two resident (R4, R7) doors that directed R4 and R7 were on droplet precautions, along with directions for personal protective equipment (PPE) use. Hand sanitizer was accessible on top of isolation bins located just outside of R4 and R7's doorways.

On 11/18/20, during continued observation at 9:39 a.m. housekeeper (H)-A was observed to enter R4's room after donning PPE and performing hand hygiene. At 9:41 a.m. H-A exited R4's room with the same PPE on and carried a small trash can of used gowns and dumped contents of can into the housekeeping cart's uncovered garbage and returned the garbage can with the same liner back into R4's room. At that time, H-A's gown was untied and hung down from the front of the gown. At 9:43 a.m. the untied gown ties made multiple direct contacts with R4's floor as she bent over to clean R4's wheelchair. H-A exited the room, removed gown and gloves in the hallway, and disposed of them in the housekeeping cart garbage. H-A did not perform hand hygiene.

- At 9:45 a.m. H-A donned gloves, entered R6's room, and cleaned off the tray table and the furniture with a wet rag. H-A exited R6's room at 9:53 a.m., removed gloves, grabbed a roll of toilet paper from the cart, and brought the toilet paper to another resident's room a few doors down. H-A did not perform hand hygiene after glove removal.

- At 9:54 a.m. H-A used non-gloved hands to grab both handles of a wheeled walker located outside of R7's room and moved it to the right side of R7's hallway isolation bin. H-A then moved a black basket of therapy supplies located on the wheeled walker's seat directly to the floor underneath the walker. At 9:55 a.m. H-A sprayed a solution on the walker and at 9:55 a.m. she used non-gloved hands to wipe the solution off

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with a dry cloth. H-A failed to perform hand hygiene after. Immediately after wiping off the walker, H-A stated the solution used was Sani-Clean 2. H-A explained the Sani-Clean 2 was sprayed on surfaces and left for "5 to 10 minutes" before being wiped dry.

- At 9:56 a.m. H-A donned gloves without having performed hand hygiene and entered R7's room without having donned a gown. H-A grabbed a small garbage can of used gowns and dumped the contents of the garbage can into the housekeeping cart's uncovered garbage, which placed H-A in the middle of the hallway, and returned the can back into R7's room. At 9:57 a.m. H-A opened R7's bathroom door with her gloved hand, turned around when NA-E approached R7's doorway with a fresh water mug, and brought the mug to R7. H-A exited R7's room with the old mug and placed it on a top corner of the housekeeping cart. H-A touched multiple cloth mop heads located on top of the cart with a gloved hand; however did not pick one up. Instead, she donned a new pair of gloves, failed to perform hand hygiene, and walked across the hall to R6's room and entered after having touched R6's room door handle. H-A exited R6's room with a spray can of glass cleaner and entered R7's bathroom. At 9:59 a.m. H-A cleaned R6's toilet without allowing the chemical to sit prior to flushing, and touched multiple clean dry cleaning rags on the cart with gloved hands once she exited the room. H-A wiped down most things in the bathroom with a wet rag; however, failed to wipe down the sink. Again, H-A touched multiple things located on the cart with her gloved hands and again entered R7's bathroom, cleaned the mirror with a designated glass cleaner, and then used the same glass cleaner to clean out the sink. At 10:01 a.m. H-A touched a stack of clean rag and

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cloth mop heads on the cart with gloved hands and used a new wet rag to clean off the light in the bathroom. At 10:02 a.m. NA-E approached H-A and questioned her on lack of gown use. H-A acknowledged NA-E; however, had finished cleaning in R7's room and did not don a gown at that time. Immediately after NA-E approached H-A, H-A removed her gloves, failed to perform hand hygiene, and handed R7's old water mug to NA-E. H-A failed to perform hand hygiene after she touched R7's mug.

- At 10:04 a.m. H-A donned gloves, entered R5's room and sprayed an instant action foaming cleaner onto R5's wheelchair which she wiped off right away after applying.

On 11/18/20, at 10:18 a.m. during continued observation H-A housekeeper H-A was observed to exit R7's room after having washed the carpet with a carpet cleaner and proceeded down the hallway to a housekeeping room where she returned with more cleaner solution. H-A had a gown on and no gloves. The gown ties at H-A's waist were not tied which exposed the H-A's uniform back. H-A stepped a few feet into R5's room with the gown on, failed to perform hand hygiene, and prepped the cleaner for operation. At 10:21 a.m. H-A entered the room's main living section where R5 was seated in a recliner, about 2 feet from her wheelchair. H-A grabbed R5's wheelchair, brought it out into the hallway, and removed the gown as she started to walk down the hallway to the housekeeping cart located by the housekeeping room. H-A threw the gown in the cart's uncovered garbage at approximately 3 feet from the cart and returned to Westwood Lane. H-A failed to perform hand hygiene after gown removal. After being placed in the garbage, sections of the gown remained exposed above the top of the garbage and hung down over the

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end of the garbage can.

- At 10:22 a.m. H-A entered R5's room and proceeded to touch the following items as she cleaned the carpet: R5's walker, tray table, bed foot board and covering, door edge, her uniform pockets. At 10:29 a.m. H-A finished cleaning the carpet, turned off the light by the doorway, and exited R5's room. H-A failed to perform hand hygiene after exiting R5's room.

When interviewed on 11/18/20, at 10:29 a.m. H-A stated she was required to wear PPE when she entered a resident room designated with droplet precaution signage. H-A acknowledged she had not tied the gown correctly when she worked in R4 and R7's rooms and that she did not wear all the required PPE when in R7's room. Further, H-A acknowledged the numerous episodes of incorrect glove use and lack of hand hygiene when she worked between R4, R5, R6, and R7's rooms, along with having worn the gown used in R4 and R7 out in the hallway. H-A stated the ties on the gowns did not "fit around me" and that she had not updated her supervisor about this. H-A voiced if the gown ties touched the floor there was a risk of "potentially contaminating things around" the room. H-A explained she had forgotten to put the gown on prior to entering R7's room and voiced she should have worn it; however, stated she did not think her incorrect actions impacted other residents as she was "just doing the bathroom and the floors." H-A voiced she was not aware of what the word droplet meant for droplet precautions. H-A stated she was expected to perform hand hygiene before entering and after exiting a resident room or before she touched items on her cart after she touched potentially contaminated items. Further, H-A explained she was expected to wear gloves when cleaning and she should remove the gloves

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also before touching items on her cart. In addition, H-A stated she was further expected to wear the gowns only inside a resident room and that the used gowns were not to be worn in the hallways. Additionally, H-A stated she should not have placed the gown haphazardly in the cart garbage as this should have been removed before she exited R7's room and disposed of correctly. H-A voiced she had never been told she was to tie the garbage bags in the residents room before exiting the room; however, did state this would be a good practice as "it could be contaminated." H-A explained she had used a Rest Stop toilet bowel cleaner to clean R7's toilet. H-A stated the manufacturer recommendation for use was to wait 10 minutes; however, H-A explained, "I do at least 5." H-A stated she used ZenaCrystal Glass Cleaner in R7's bathroom and she acknowledged using this on the sink. H-A explained glass cleaner was to only be used on glass surfaces and she should have used Sani-Clean 2 on the sink instead. H-A read the instructions for use of the Sani-Clean and verbalized it should remain on a surface wet for 10 minutes. H-A acknowledged incorrect use of the Sani-Clean on the therapy wheeled walker. In addition, H-A voiced she had not received training on the chemicals she was expected to use; however, she tries to keep things cleaned the best she can.

During interview on 11/18/20, at 11:05 a.m. housekeeping director (HD) stated Sani-Clean 2 was the main chemical used for cleaning in the facility, especially in resident bathrooms. HD explained the process when she used Sani-Clean 2 was to spray it on a surface, let it sit for two to three minutes, and then wipe it off "a little bit" so that it air dries; however, HD acknowledged the manufacturer instructions were for it to stay wet

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anywhere from 8 or 10 minutes. HD explained her staff could not leave it on the surfaces that long due to "people walking around." HD stated housekeeping also used an instant action foaming cleaner for other surfaces the Sani-Clean 2 was not used on. HD explained the directions for use were to keep on surfaces for about 2 minutes; however, when the can was examined, the instructions directed for staff to let sit for 10 minutes. HD explained her staff did not have that much time to let it sit on surfaces for that long. HD acknowledged staff were expected to follow the manufacturer instructions for use; however, explained due to work load and the number of housekeeping staff available, if staff followed the manufacture instructions for cleaning, they would not get all of their required cleaning work completed each day. HD denied having had conversations with the current administration about the cleaning instruction time frame concerns for the chemicals used in the facility. HD stated housekeeping staff were expected to wear all PPE as instructed, which should be removed inside the residents room and not worn outside the room. Further, HD explained she expected staff to wear gloves and perform hand hygiene as directed. In addition, HD stated she expected housekeeping staff to dispose of PPE as directed and to dispose of used PPE gowns by removing the bag from the trash can prior to placing the garbage bag in the cart trash. HD verbalized if staff did not follow infection control practices as directed she "would think that is a serious infection control issue as you have contaminated and exposed all those people to everything," and, "everyone could be sick." HD denied she has performed any recent audits as she "does not have the time" to do them or "follow up" on her staff. HD explained her staff had been trained on the Sani-Clean approximately five

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months ago; however, stated she does not document any training.

When interviewed on 11/18/20, at 2:08 p.m. the director of nursing (DON) stated housekeeping does all the cleaning; however, all staff were expected to follow the manufacturer instructions as the facility used a "variety" of cleaning products. Further, the DON explained all staff were expected to perform hand hygiene and to wear PPE as directed, that gowns were to be removed prior to exiting resident rooms identified on transmission based precautions, and that PPE was disposed of also as directed. The DON stated if staff were not following infection control guidelines there was a potential for them to "spread infection to residents and staff."

A Sani-Clean 2 manufacturer label, undated instructed staff for disinfecting and cleaning to, "Let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry."

A Rest Stop restroom disinfectant manufacturer information sheet, undated instructed staff when toilet bowls were cleaned to, "Allow product to remain on surface for a contact time of 10 minutes; then flush toilet."

A ZenaCrystal glass cleaner manufacturer information sheet, undated, indicated, "use to clean mirrors, windows, automotive glass, and other glass surfaces."

HAND HYGIENE

During a continued observation on 11/18/20, at 1:08 p.m. NA-D was seated at the corner of a dining room table feeding R8 and R9. At 1:11

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p.m. NA-D fed R8 and R9 without using a designated hand for each resident. NA-D touched R9's hands as she assisted her to hold a glass of liquid. At 1:14 p.m. NA-D touched the divided plate of R9. At 1:16 p.m. NA-D wiped R8's face with a napkin using her right hand, picked up R9's silverware with her right hand, and started to feed R9. NA-D did not perform hand hygiene during these observations.

- At 1:18 p.m. NA-C entered the dining room carrying a resident room tray and placed it in a metal cart of other used meal trays. After, NA-C sat next to R8 and took over assisting R8 to eat. At 1:19 a.m. NA-C approached R10 and touched his wheelchair, silverware, and placed a cup in his hand. Immediately after, NA-C walked over to R11 and touched R11's head and fed her a bite of food. Immediately after, NA-C walked back to R8, touched her own hair as she sat down, and picked up R8's silverware. NA-C did not perform hand hygiene during these observations.

- At 1:21 p.m. NA-D touched her face mask with her right hand and then fed R9 using the same hand. At 1:24 a.m. NA-D walked over to R12 and handed him a cup of coffee and removed his meal tray from the table. As she placed the meal tray in the metal container, she knocked over cups on the metal tray onto the floor. After NA-D picked up the cups, she walked R14 down to the day room where she handed R14 a cup of coffee and used the TV remote. R14 immediately drank from the cup. NA-D did not perform hand hygiene during these observations.

-At 1:28 p.m. NA-C, after picking up meal trays, handed R9 a glass which R9 immediately drank from. When R9 finished drinking, NA-C cleaned R9's mouth area with a clothing protector. NA-C brought the clothing protector to the designated laundry bin and touched the bin lid

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with bare hands to lift it. After, NA-C touched her own hair, took off another resident's clothing protector and placed the remaining trays in the metal cart. At 1:31 p.m. NA-C placed a transfer belt on R10 and transferred him to a recliner. NA-C did not perform hand hygiene during these observations.

During observation hand sanitizer was observed to be absent from the dining room tables. The only accessible sanitizer station was just inside the dining room, hanging on the wall which would have required staff to get up through out the meal to sanitize frequently.

During interview on 11/18/20, at 1:34 p.m. NA-C stated hand hygiene was required before feeding residents and before and after touching them. NA-C acknowledged she did not perform hand hygiene during observation from 1:18 p.m. to prior to assisting R10 into the recliner. NA-C stated not performing hand hygiene at the required times risked getting the residents "sick."

When interviewed on 11/18/20, at 1:40 p.m. NA-D stated hand hygiene was required before and after resident cares, before assisting a resident to eat, "before anything, " and, "after everything." NA-D acknowledged she had washed her hands prior to starting feeding assist in the dining room; however, denied having performed hand hygiene after that or throughout the remainder of the observation period. NA-C stated not performing hand hygiene at the required times risked, "definitely them getting sick or an infection."

During interview on 11/28/20, at 2:08 p.m. the DON stated she would expect hand hygiene to be performed after any physical contact with a

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resident. The DON explained if staff were not following infection control guidelines there was a potential for them to "spread infection to residents and staff."

COMMUNAL DINING:

During observation on 11/18/20, at 1:08 p.m. 12 residents were seated around 6 tables in the memory care dining room. Each table was within six feet of at least one other adjacent table. All residents in the memory care dining room (R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18) except for R19 were observed to be approximately 3 feet from each other. R19 was the only resident observed to be socially distanced at 6 feet during meal time. The dining room floors or tables did not show visible indicators of placement reminders to ensure social distancing was maintained and there were no indicators to direct staff of resident placement.

On 11/28/20, at 1:18 p.m. NA-C was observed to enter the dining room and sat on the right side of R8, where NA-C was positioned across from NA-D and R9, and started to assist R8 with eating. NA-D continued to assist R9 with eating.

During interview on 11/18/20, at 1:34 p.m. NA-C stated knowledge of communal dining social distancing guidelines. NA-C explained residents typically sat in the same spot each meal; however, voiced with COVID-19 the staff try to spread the residents out. NA-C denied she attempted to place residents at different spots during the noon meal or encouraged them to spread out. NA-C acknowledged the residents were not socially distanced during the noon meal;

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however, explained she did not feel there was enough room to maintain social distancing for all residents eating in the dining room.

When interviewed on 11/18/20, at 1:40 p.m. NA-D stated knowledge of communal dining social distancing guidelines. NA-D explained, "We try our best to social distance but it is very hard." Further, NA-D explained the residents who required feeding assistance were the hardest residents to social distances as "we have to feed them at the same time" and "we do not always have three aides back here." NA-D acknowledged the residents were not socially distanced during the noon meal and denied she had attempted to place residents at different spots during the meal or encouraged them to spread out.

During interview on 11/18/20, at 1:50 p.m. registered nurse (RN)-C stated knowledge of communal dining social distancing guidelines. RN-C voiced he had entered the dining room around 12:30 p.m. that afternoon to observe for social distancing issues during the noon meal and stated he did not see concerns at that time. RN-C had not been able to recall which residents were present in the dining room or where they were seated during RN-C's observation. After RN-C had been verbally updated on the residents' seated pattern during the 1:08 p.m. observation, RN-C acknowledged all but one resident had not maintained social distancing during the meal.

On 11/28/20, surveyor's continued observational notes did not reflect RN-C entering the dining room from 1:08 p.m. to 1:33 p.m.

When interviewed on 11/28/20, at 2:08 p.m. the

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21375	Continued From page 45 DON stated she expected staff to make sure social distancing of at least 6 feet was maintained during meals. The DON explained she had not observed the dining room during a meal "for some time" and had not been aware of issues regarding staff concerns in regards to social distancing. The DON stated staff have moved recliners and chairs in the memory care unit to help ensure social distancing in the lounge areas; however, she voiced that "things get moved around." The DON denies no specific actions have been taken to ensure social distancing in the dining room for meals; however, she stated, "We have talked about it." The DON explained if staff were not following infection control guidelines there was a potential for them to "spread infection to residents and staff." A facility policy Personal Protective Equipment, revised 3/2/20 identified, "PPE includes gloves, masks, protective gowns, eye wear, and face shields." Further, the policy identified the following: "PPE is required for entry into isolation rooms and removal is required prior to leaving isolation rooms;" gloves should be worn when handling items that may be contaminated and when entering isolation areas; do not wear gloves in designated clean areas and remove before leaving a treatment area; immediately wash hands after removing gloves and glove use does not replace hand hygiene; gowns will be applied prior to entering treatment area and should not be worn in designated clean areas; gowns should be large enough to cover the clothing of the person using the gown and should be removed before leaving the treatment area. In addition, the policy directed when applying the gown all clothing is completely covered and be secured at the waist strings.	21375		

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21375	Continued From page 46 A facility policy Hand Hygiene, revised 9/17/20 instructed hand hygiene was to be performed before applying gloves or other PPE and after their removal, after potentially contaminated items were handled, and after contact with inanimate objects in the immediate vicinity of a resident. A facility policy Cleaning and Disinfection of Resident Rooms or facility areas of Suspected/Confirmed COVID-19, dated 6/23/20 indicated staff were to follow the manufacturer's instructions for all cleaning and disinfection products for concentration, application method and contact time, etc. Further, the policy directed environmental services staff and others should clean hands often, including immediately after glove removal and that environmental services staff should wear disposable gloves and gowns for all task in the cleaning process, including handling trash. A facility COVID-19 policy, revised 10/19/20 identified, "Communal dining limited (for COVID-19 negative or asymptomatic residents only), residents may eat in the same room with social distancing. Limitations will be considered based on COVID-19 infections in the facility." Further, the policy identified, "Residents should remain 6 ft [feet] apart if in communal areas." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on COVID-19; then educate staff on ensuring adequate social distancing and housekeeping procedures to prevent the spread of the disease. They could then audit to ensure compliance.	21375		

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21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has	21830		12/23/20

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executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: _____ B. WING _____	C 11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 49 county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the appointed guardian was notified in a timely manner of refused treatments for 1 of 1 residents (R2) reviewed who refused required laboratory monitoring and subsequently missed multiple doses of prescribed antipsychotic medication. Findings include: A submitted state agency (SA) Incident Report, dated 11/6/20, identified a facility' reported allegation of sexual abuse involving R2 and another female resident. The report outlined R2 had been found in R1's room " ... having sexual intercourse." The report outlined the police were contacted and removed R2 from the facility. R2's quarterly Minimum Data Set (MDS), dated 9/29/20, identified R2 had schizophrenia along with moderate cognitive impairment. Further, R2 demonstrated no hallucinations, delusions or rejection of care(s) behaviors. Further, R2's Admission Record, printed 11/18/20, identified an	21830	Corrected	

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21830	Continued From page 50 appointed guardian (G)-A as his responsible party. On 11/13/20, at 12:22 p.m. G-A was interviewed. G-A explained she was aware of an incident which had happened involving R2 sexually assaulting another resident while residing at the nursing home, and expressed frustration as R2's mental state had been "stable until he went off his meds." G-A voiced she had not been notified until weeks afterwards, on 11/2/20, that R2 had refused the laboratory monitoring and subsequently had not been provided his ordered antipsychotic medication. G-A voiced frustration at the lack of timely notification and expressed the facility had held a care conference with her towards the end of October, and still even then "not one word" of the refusal and held medication was mentioned. R2's progress note, dated 10/19/20, identified the pharmacy came to deliver R2's antipsychotic medication and draw routine laboratory work. R2 refused and threw his coffee at the employee. The note outlined, "Pharmacy unable to delivery [sic] medication since resident refused lab draw." The note identified registered nurse (RN)-A was updated. R2's Medication Administration Record (MAR), dated 10/2020 to 11/2020, identified R2's physician ordered medications and their subsequent administration record(s). An order was listed for clozapine (an antipsychotic medication) 500 milligrams (mg) everyday; which had a listed start date of 6/25/20. The medication was record as being given and consumed by R2 until 10/20/20. From 10/21/20 to 11/5/20, the MAR identified nearly all subsequent doses of the medication were not given with numerous entries	21830		

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21830	Continued From page 51 of, "18," which was identified via legend as, "Med not available from pharmacy." Further, R2's Care Plan Conference Summary, dated 10/23/20, identified a quarterly care conference had been held with G-A in attendance along with RN-A and licensed social worker (LSW)-A. A section labeled, "Psychotropic Med Review," was listed which outlined R2's medications had been reviewed and informed consents were on file. The completed form lacked any evidence R2's refused laboratory monitoring, and the subsequent holding of his ordered antipsychotic medication, was discussed or reviewed. R2's medical record, including recorded progress notes, were reviewed and lacked evidence R2's appointed guardian had been immediately notified of the refused laboratory monitoring and his antipsychotic medication being held as a result. On 11/13/20, at 1:07 p.m. RN-A and LSW-A were interviewed. They verified R2 had refused his laboratory draw on 10/19/20, and his clozapine was held as a result because the pharmacy would not leave the medication without the laboratory draw being completed to ensure R2 was safe to continue taking the medication. They reviewed R2's medical record and acknowledged it lacked evidence R2's guardian had been updated on those events, and voiced the cart nurses should have ensured G-A was updated on 10/19/20. LSW-A verified a care conference was held for R2 on 10/23/20, and the laboratory draw and medication hold was not discussed as she "wasn't fully aware of all of this [those events]" until R2 was hospitalized on 11/3/20. RN-A expressed R2's guardian should have been updated "right away."	21830		

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21830	Continued From page 52 When interviewed on 11/17/20, at 11:32 a.m. the director of nursing (DON) stated she was unsure of the exact date when R2's guardian had been formally notified of the refused laboratory draw and subsequent antipsychotic medication being held; however, recalled it being the week of 10/26/20 at some time (at least six days later). The DON voiced her expectation would have been for R2's guardian to be updated the same day the laboratory draw was refused. A provided Change in Condition policy, dated 12/19/18, identified a purpose of ensuring prompt notification of changes in the resident's physical, psychosocial and/or mental status to the physician and/or responsible party. The policy outlined several examples of issue(s) which required 'prompt notification' including, "A need to alter the resident's medical treatment significantly," and, "Refusal of treatment or medications (i.e. two (2) or more consecutive times)." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON, or designee, could review applicable policies and procedures and inservice staff on timely notification to resident representatives and/or guardians; then audit resident charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		