Electronically delivered
January 21, 2021

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

RE: CCN: 245461
Cycle Start Date: January 8, 2021

Dear Administrator:

On January 8, 2021, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, 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: kathleen.lucas@state.mn.us
Phone: (320) 223-7343

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 8, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 8, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 21, 2021

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

Re: Event ID: 5SWQ11

Dear Administrator:

The above facility survey was completed on January 8, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE LUTHERAN HOME	**1405 7TH STREET SOUTH MOORHEAD, MN 56560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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 1/8/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaints were found to be substantiated: H5461048C, H5461049C	2 000		

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2 000	Continued From page 1 NO licensing orders were issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state 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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F 000	INITIAL COMMENTS On 1/8/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5461048C, H5461049C, with a deficiency cited at F600. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	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.	F 600		2/26/21

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

Electronically Signed | 01/28/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 §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 interview and document review, the facility failed to ensure residents were free from abuse for 1 of 3 resident (R1) reviewed who was hit by (R2) in the facility. R1 R1's quarterly Minimum Data Set (MDS) dated 10/13/20, identified R1 had severe cognitive impairment and diagnoses which included: Alzheimer's disease, dementia and hypertension. R1's MDS further identified he had physical behavior symptoms directed towards others 4-6 days during assessment period and verbal behavior symptoms towards others 1-3 days during assessment period. R3's MDS indicated R3 did not walk, required total assistance with transfers and extensive assistance with all other activities of daily living (ADLs). R1's care plan revised 10/19/20, identified R3 had self care deficit related to dementia and decreased mobility with need for assistance of 1 staff with ADLs. R3's care plan further identified R3 had a history of resident to resident altercations and severity of behaviors depends on the triggers; more severe when taking things from him or being told what to do. R3's care plan identified R3 was a vulnerable adult due to placement at the skilled nursing facility and cognitive deficits with a goal to maintain dignity of	F 600	F600- Free from Abuse and Neglect 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. When R2 is in a communal area, he is supervised by staff and if another resident comes in, R2 will be removed from that area. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who reside on 2nd floor have the potential to be affected. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. We will utilize an assessment method to proactively identify individuals at high risk for behavioral incidents and educate staff on triggers for these individuals behaviors and how to deescalate behaviors after these triggers have been identified to prevent harm. 4.How the facility will monitor its corrective	

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F 600	Continued From page 2 living in a safe environment. R3's interventions included staff were to observe for, intervene and report any signs of neglect or abuse if necessary. On 1/8/21, at 10:36 a.m. R1 was sitting in a high back reclined wheelchair in a sitting area near his room facing the window. R1's was dressed in street clothes with his eyes closed, no other residents near him. At 11:03 a.m. R1 was in his wheelchair in his room, television on playing music, R1 appeared calm and smiled at surveyor with no verbal response. At 12:23 p.m. R1 again in hallway near his room in sitting area, eyes open, no residents near him at this time. Review of R1's progress notes from 10/1/20, to 1/8/20, identified the following: -10/25/20- staff witnessed another resident kick R1 in the legs, R1 turned to hit the other resident's feet then staff separated, no injuries. -1/6/21, R1 was sitting in the hallway next to the secretary area, when another resident wheeled up to him and hit him on the left side of his head with his arm. Staff immediately separated, no injuries noted. R2 R2's quarterly MDS dated 10/20/20, identified R2 had severe cognitive impairment with diagnoses which included; non-traumatic brain dysfunction, encephalopathy (damage or disease of the brain) and Parkinson's disease (progressive nervous system disorder that affects movement). R2's MDS identified he had physical behavior symptoms directed towards others 4-6 days during assessment period and other behaviors	F 600	actions to ensure that the deficient practice is being corrected and will not recur. A post-education evaluation will be completed. The DON or designee will complete 15 audits of residents who were identified as being at high risk for behavioral incidents weekly for 1 month to ensure all have an appropriate plan to address potential abuse. To follow, 12 audits of residents who were identified as being at high risk for behavioral incidents will be completed every other week for 3 months. For 8 months thereafter, there will be 6 audits per month conducted on residents who were identified as being at high risk for behavioral incidents. If concerns are identified, corrective action will be implemented. Audit results will be reported at the quality meeting to include interventions and follow up with interventions. 5.The date that each deficiency will be corrected: 2/26/2021.	

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F 600	Continued From page 3	F 600		

not directed towards others 4-6 days during the assessment period. R2's MDS further identified R2 did not walk, required total assistance with transfers and extensive assistance with all other ADLs.

R2's care plan revised 12/17/20, identified R2 had self care deficit and required assistance with all ADLs and a mechanical lift for transfers. R2's care plan identified R2 frequently grabbed out or reached for things with a history of pinching and grabbing other residents. R2's care plan identified triggers for behaviors included noise/commotion, seeing objects he liked and getting too close to objects or other people. R2's interventions included; to keep resident out of arms (reach) from other residents at all times, complete 30 minute checks on R3, candy bar daily around 10:30 a.m., headphones for music and watching cartoons, animated movies or sports. R2's care plan identified he was a vulnerable adult and staff were to observe for, intervene and report any signs of neglect or abuse if necessary.

On 1/8/21, at 9:28 a.m. R2's door was closed. After knocking surveyor entered room, R2 was lying on his bed with his t-shirt pulled up over his head with no other clothing or linen covering him. R2 did not respond to surveyor. At 12:25 p.m. R2's door closed, TMA-A and surveyor entered room and R2 was lying on his bed, t-shirt pulled over his head, no other clothing on. TMA-A pulled down and straightened R2's t-shirt, with no response from R2. At 2:45 p.m. R2's door was closed, surveyor knocked and opened door, R2 said "hi", while lying in bed, with eyes open. R2 wore a t-shirt appropriately and a brief.

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F 600	Continued From page 4	F 600		

Review of R2's progress notes 10/1/20, to 1/8/21, identified the following;

-10/25/20, R2 wheeled over from lounge area and began kicking another resident's legs. R2 was then struck on his feet by the other resident. R2 was separated from the other resident then R2 was taken back to his room. R2 sustained no injuries.

-10/28/20, at 8:58 a.m. R2 was sitting in common area and wheeled to another resident and grabbed their shirt, staff immediately intervened. R2 was smiling and did not appear angry, R2 redirected to watch cartoons, other resident moved from area. R2 then began thrashing and removing clothing until staff were able to sit with him and assist with breakfast.

-10/28/20, at 11:48 a.m. R2 grabbed a female resident's walker as she walked by and attempted to take it from her, staff intervened and redirected R2.

-10/28/20, R2 behavioral review; R2 continued to have frequent behaviors which included touch, kick, grab, pull or push objects and people within arms reach and behaviors noted with cares. Interventions for R2's behaviors included redirection, leave and re-approach, distraction, move to less stimulating area, and diversional activities with overall interventions not effective. R2 has also pulled staff's hair, pulled his brief off multiple times a day, yell and threw objects on the floor. Staff offer interventions which were effective for short periods of time, then R2 would continue to have destructive behaviors. R2 able

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F 600	Continued From page 5	F 600		

to self propel on the unit and would push, pull, move, throw and grab objects. R2 being followed by psychiatric provider closely and received medications for behaviors. R2 had a history of resident to resident altercations. R2 was on 30 minute checks, R2's behaviors continued to escalate so R2's behaviors monitored and reviewed to determine when most behavioral and to establish interventions during these times to assist in decreasing behaviors.

-12/12/20, R2 was in hallway then wheeled self into another resident's room. Staff removed him from area and brought out to watch television in lounge area. R2 began to kick cushions off couch, then proceeded towards another resident and before staff could intervene he grabbed a resident on her left wrist and pulled. Staff separated them immediately and removed R2 from the area. R2 then taken to his room to lay down and watch television.

-12/14/20, R2's behaviors discussed with IDT (interdisciplinary team). R2's care plan and interventions reviewed and appropriate. Activities would assist R2 with distractions as able and candy bar would be offered around 10:00 to 11:00 due to R2 had history of more behaviors at this time. R2's psychiatric provider updated.

-1/5/21, R2 quite most of shift, then had tried to go into another resident's room. R2 moved and flipped furniture, took cushions off couch, shredded his brief and was opening and closing fish tank cabinet doors. Staff offered snack and turned on cartoons and completed a 1:1, but behaviors only stopped for a period.

-1/6/21, R2 wheeled up to another resident and

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F 600	Continued From page 6	F 600		

hit him in the head using his right hand and also tried to grab the residents arm, staff immediately separated them. R2 had been restless prior to incident and threw couch cushions off in lounge area and ripped his brief. Staff had put cartoons on before incident, then laid R2 down in his room after the incident, now sleeping. Fax sent to psychiatric provider.

-1/7/21, Depakote (seizure medication) lab drawn, then results faxed to psychiatric provider. Fax received from psychiatric provider with questions which included; was this a one time incident and had R2 had increased agitation overall. If a one time incident would not recommend an increase of the Depakote.

-1/8/21, phone call attempt made to R2's past case manager and voice mail left with call back number.

The facility incident report, submitted to the state on 10/25/20, identified staff witnessed R1 and R2 in the common area not near each other. Then R2 wheeled by R1 and began kicking R1. R1 then began to hit R2's feet when staff intervened. The facility investigation submitted 10/28/20, identified no injuries occurred for both residents. Staff interviews were completed and found R2 was having behaviors prior to the incident by throwing furniture and other items in the common area. Staff had provided interventions earlier for these behaviors which were found effective. Staff reported that R2 had history of grabbing at people and items or kicking things that he was near. Actions taken to prevent reoccurrence included ongoing education and updates to staff, R2's primary provider and psychiatric provider updated

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F 600	Continued From page 7	F 600		

and 30 minute checks completed on R2. R2's behaviors also were being monitored and documented every 30 minutes. Similar incidents identified R2 involved in resident to resident altercations on 6/27/20 and 7/13/20, with different residents. R1 and R2 had no prior incidents reported.

The facility incident report submitted to the state on 1/6/21, identified R1 and R2 were sitting on opposite sides of the lounge area when staff witnessed R2 propel himself towards R1 then he struck R1 twice on the forehead. Staff immediately separated the residents, R2 was then laid down in his room with a movie and R1 had sustained no injuries.

On 1/8/21, at 10:48 a.m. nursing assistant (NA)-A indicated R1 required total assistance with cares, and could be combative with cares, but did not think he was towards other residents. NA-A indicated she was not aware of a recent altercation R1 was involved in. NA-A indicated she felt R2 thought he was a child and acted like one. NA-A indicated R2 would remove his clothing, and had hit a few residents. NA-A indicated interventions included that when R2 was up in his wheelchair, they put him in the lounge by the television and no other residents could be in the area with him. NA-A indicated she thought he hit another resident a few days ago, she was not sure but thought it was R1. NA-A indicated other interventions included singing, chocolate bars and remind him of his sister.

On 1/8/21, at 1:14 p.m. during a phone interview, trained medication aide (TMA)-A indicated she had witnessed the resident to resident altercation on 1/6/21. TMA-A indicated she had heard R1

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EVENTIDE LUTHERAN HOME	**1405 7TH STREET SOUTH MOORHEAD, MN 56560**

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hollering when she looked , she seen R2 had hit R1 on the head with his hands. TMA-A indicated R2 was unable to make a fist and had struck R1 with an open hand. TMA-A indicated R2 then struck R1 a second time before she was able to intervene. TMA-A indicated she moved R2 away from R1, then licensed practical nurse (LPN)-A worked with R2, while she stayed with R1 to calm him down. TMA-A indicated she did not see any injuries, but R1 had been upset after the incident. TMA-A indicated she did not believe R1 had any lasting effects from the incident, with no changes noted in him. TMA-A indicated new interventions included when R2 was in the common areas, no other residents were to be near him.

On 1/8/21, at 1:42 p.m. TMA-B indicated R1 could be combative with cares at times, but was not aware of R1 striking other residents. TMA-B indicated R2 would throw anything he could get his hands onto the floor and he would rip his brief off. TMA-B indicated they could not use sheets on his bed because he would wrap them around his neck. TMA-B indicted R2 had the mind set of a child. TMA-B indicated if R2 was up in his wheelchair, they did not have any other residents near him, they would redirect other residents away from his area. TMA-B indicted R2 moved his feet a lot, so other residents avoided going near him. TMA-B indicated R2's dresser was bolted to the wall because he had overturned it once. TMA-B indicated she was not aware that R2 had any recent altercations with other residents.

On 1/8/21, at 1:52 p.m. LPN-B indicated R1 could become impulsive and strike others, or yell. LPN-B indicated R1 was being seen by a psychiatric provider. LPN-B indicated she was

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aware of the resident to resident altercation between R2 and R1. LPN-B indicated new interventions included to keep R1 and R2 separated. LPN-B indicated if R2 was in the common areas, staff were to keep other residents away from him, so he would not harm anyone, and also to keep objects away from him. LPN-B indicated R2 had a long history of throwing objects. LPN-B indicated R2 would throw things, flip furniture like bedside tables, throw items on the floor and would not keep his clothing on. LPN-B indicated R2 had a history of altercations with residents, and the main intervention was to not have other residents near him. LPN-B indicated redirection usually did not help with R2's behaviors. LPN-B indicated he had recently had a Depakote level drawn.

On 1/8/21, at 2:10 p.m. resident care manager (CM)-A indicated R1's behaviors had decreased, but R1 would still holler or push away at staff during cares. CM-A indicated she was aware of the altercation with R2 and R1. CM-A indicated R2 was a difficult resident and one of his interventions included watching television in the common areas, and he liked to be around other people. CM-A indicated R2 would destroy his room, and if he sees something he would go for it. CM-A indicated R2 hit out at staff also. CM-A confirmed abuse had occurred, due to R2 hit R1. CM-A indicated R2 interventions included to keep R1 and R2 apart and all staff were aware of R2's behaviors and interventions. CM-A indicated she had attempted to contact R2's previous case manager, and was waiting a return call. CM-A indicated they updated R2's psychiatric provider after every altercation R2 was involved in, and indicated the last time R2's

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medications had been altered with no real improvement in behaviors. CM-A indicated they kept other residents safe in the facility by keeping them out of R2's reach, but indicated they were unable to do 1:1 supervision around the clock with R2 at the facility, but they did frequent checks on him. CM-A indicated other interventions used included candy bars, cartoons on the television, and other interventions that have been helpful but for a short time. CM-A indicated they had discussed R2 with IDT, they discussed a possible other type of setting for R2 rather then their facility. CM-A indicated the social worker on their unit's last day was yesterday, but another social worker was aware and was taking over for them. CM-A indicated R1 had no lasting effects or injuries from the altercation between R2 and R1. CM-A indicated the staff had received dementia training and vulnerable adult abuse prevention training annually and they reviewed policies. CM-A indicated they brought up the policies after any altercations happened and they discussed interventions to use together. At 2:50 p.m. during a follow up interview CM-A indicated they had several interventions to use for R2's behaviors. CM-A indicated for any altercations, they have updated his psychiatric provider and the last time he ordered R2's Depakote level to be drawn. CM-A indicated R2's psychiatric provider asked them if this was an isolated incident, which it was not, and if his behaviors were getting worse. CM-A indicated the last time he had an altercation his Depakote was increased and R2's sister brought in candy bars to distract R2. CM-A indicated they have continued with his interventions and R2 has never hurt any one. CM-A indicated they keep other residents safe when he is out of his room by keeping others out

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of his reach, and staff did 15 minute checks on him. CM-A indicated she felt they were keeping other residents safe the best they could by not isolating him in his room or completing 1:1 supervision which they could not provide ongoing. CM-A indicated they have discussed moving R2 to a different facility which they felt better for R2 and the safety of other residents in the facility. CM-A indicated she had tried to get a hold of R2's case manager and after they get in touch with her, they planned that the social worker would reach out to other facilities and involve R2's family with the decision for a possible move.

On 1/8/21, at 3:32 p.m. licensed social worker (LSW)-A indicated she was aware of the altercation between R2 and R1 and was aware of R2's behaviors. LSW-A indicated R2 could propel his self in his wheelchair, but could only go a little ways. LSW-A indicated they were reaching out to behavioral health, and wanted to contact his case manager who had worked with R2 in the past. LSW-A indicated they had attempted to contact her a couple of times so far. LSW-A indicated that dependent on their conversation with the case manager, they may be looking at a different environment for R2, like a group home. LSW-A indicated she was not aware of any residents who were fearful of R2. LSW-A indicated she was aware that R2's Depakote had been increased 2 days prior to the incident. LSW-A indicated she did not know R2 well, but had assisted with getting R2 his private room.

On 1/8/21, at 3:42 p.m. R4 indicated she felt safe at the facility. R4 indicated there were no residents she did not feel safe with or get along with. R4 confirmed she left her room more often

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now, and felt safe.

On 1/8/21, at 3:53 p.m. director of nursing (DON) indicated she was aware of the altercation between R2 and R1 and that R2 was impulsive and had no predisposition of behaviors, but if he got close enough with other residents he could make contact with them. DON indicated R1 sustained no injuries that she was aware of and they had separated R1 and R2 and were to keep them apart. DON indicated there was a balance between not restraining R2 to his room and keeping other residents safe. DON indicated they kept other residents safe with R2's supervision and when he is out in common areas, they kept other residents out of the area. DON indicated they had spoken on Wednesday and they questioned if their facility was the best place for R2. DON indicated their plan was to reach out to R2's power of attorney to discuss what had been done in the past, because R2 had been at another skilled nursing home prior to his admission to their facility. DON indicated she thought a foster home may be a better fit for R2. DON indicated her expectations were to keep their residents safe at all times. DON indicated they did not know if they could continue taking care of R2, and now when R2 came out of his room, they kept him in areas others were not in, and staff took turns watching R2.

On 1/8/21, at 4:04 p.m. Administrator indicated she was notified of the incident between R1 and R2 by text. Administrator indicated they held meetings called Safe Care Prevention, and they were notified of types of concerns and investigated them once reported to the state. Administrator indicated they had discussed if their facility was the appropriate setting for R2 and if

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he would need a better behavioral unit. Administrator indicated their social worker was looking into alternative placement to better suite R2's needs, they could not restrain him, and they were to always keep him away from other residents. Administrator indicated staff would have him sit by the nurses station or other common areas or by windows.

The facility policy titled Vulnerable Adult-Minnesota revised 9/19, identified the purpose of the policy was to provide safe services and living environments for vulnerable adults, and to require the reporting of suspected abuse. The policy identified that all alleged violations involving abuse, would be reported immediately but not later than 2 hours. The policy identified abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual had intended to inflict injury or harm. The policy further identified if resident to resident abuse occurred, nursing staff would separate the involved residents and immediately implement a plan to keep the resident reported as the perpetrator away from the involved resident plus limit interaction with others as assessment of the initial situation occurred. The plan of care would then be changed as needed to reflect type/frequency or observation of the the resident and the internal investigation would continue.