Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 31, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: CCN: 245512
Cycle Start Date: July 15, 2021

Dear Administrator:

On August 3, 2021, we notified you a remedy was imposed. On August 19, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 15, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 18, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 3, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 15, 2021. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Electronically delivered

August 31, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Re: Reinspection Results
Event ID: DJIC12

Dear Administrator:

On August 19, 2021 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 August 19, 2021. At this time these correction orders were found corrected.

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

Electronically Submitted
August 3, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: CCN: 245512
Cycle Start Date: July 15, 2021

Dear Administrator:

On July 15, 2021, 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 widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 15, 2021, 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 F.

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 August 18, 2021.

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 August 18, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 18, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 15, 2021. This prohibition is not subject to appeal. 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.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, First Care Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 15, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division

Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 15, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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
	245512	A. BUILDING ______ B. WING ______	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/12/21 through 7/15/21, a standard abbreviated and extended survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5512038C (MN74548), with a deficiency cited at F600. As part of the investigation related deficiencies were cited at F607, F609, F610. The following complaint was found to be UNSUBSTANTIATED: H5512039C (MN74696) The survey resulted in substandard quality of care and Immediate Jeopardy (IJ) situations to resident safety at F600. he IJ began on 3/7/21, when it was reported nursing assistant (NA)-A and NA-B used profanity and called R3 names, this was not reported to the SA and the residents were not provided immediate protection from further abuse. On 3/8/21, it was reported by staff that NA-A and NA-B were in R2 and R4's room swearing, making inappropriate jokes and being "rough" with R2 and R4 in the room; this allegation was not reported and the residents were not provided immediate protection from further abuse. On 4/5/21, a staff member reported NA-A told R2 to shut the F*** up, this allegation was not reported and the residents were not provided immediate protection from further abuse. Along with another grievance on 4/5/21, where a resident had concerns about how	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/11/2021

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 000	Continued From page 1 he was treated by NA-A. On 6/18/21, staff members reported NA-A made inappropriate comments to and about R1 during cares, this allegation was not reported timely and again the residents were not provided protection from further abuse. The administrator and director of nursing (DON) were informed of the IJ on 7/12/21, at 4:45 p.m. The IJ was removed on 7/15/21, at 10:55 a.m. when the facility provided evidence they had removed the immediacy. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=L	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-	F 600		8/15/21

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F 600	Continued From page 2 §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 report allegations of abuse to the state agency (SA) as required; provide resident protection during investigation for 4 of 4 residents (R3, R4 R2, R1) reviewed for allegations of staff to resident abuse. This resulted in an immediate jeopardy (IJ) situation for R3, R4 R2, R1 who all had allegations of abuse by the same nursing assistant and the facility failed to provide protection from ongoing abuse and had the potential to all residents residing in the facility. The IJ began on 3/7/21, when it was reported nursing assistant (NA)-A and NA-B used profanity and called R3 names, this was not reported to the SA and the residents were not provided immediate protection from further abuse. On 3/8/21, it was reported by staff that NA-A and NA-B were in R2 and R4's room swearing, making inappropriate jokes and being "rough" with R2 and R4 in the room; this allegation was not reported and the residents were not provided immediate protection from further abuse. On 4/5/21, a staff member reported NA-A told R2 to shut the F*** up, this allegation was not reported and the residents were not provided immediate protection from further abuse. Along with another grievance on 4/5/21, where a resident had concerns about how he was treated by NA-A. On 6/18/21, staff members reported NA-A made inappropriate comments to and about R1 during cares, this allegation was not reported timely and again the residents were not provided protection from further abuse. The administrator and	F 600	F 600 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R1 was unable to be interviewed due to his passing from end stage prognosis on 7/16/21. R2 was interviewed on 7/12/21 and relayed concerns with NA-A that were consistent with staff reports to MDH about NA-A during the survey. R3 and R4 were interviewed on 7/12/21 and did not raise concerns regarding verbal or other abuse during the interviews. All other residents (in addition to R2, R3, and R4) were interviewed on 7/12/21 and 7/13/21 did not raise concerns regarding verbal or other abuse during the interviews. On 7/12 and 7/13, nursing home staff were interviewed and asked to identify any concerns of potential resident abuse. A potential concern was identified regarding R2 and NA-B. This concern was immediately reported to the Administrator and SA on 7/14/21. MDH reviewed this report and closed it on 7/16/21. This concern was not substantiated. Notwithstanding, for the sake of being thorough, from 7/19 to 7/31, charge nurses conducted care observations/audits of NA-B during her worked shifts, with no concerns noted.	

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F 600 Continued From page 3
director of nursing (DON) were informed of the IJ on 7/12/21, at 4:45 p.m. The IJ was removed on 7/15/21, at 10:55 a.m. but noncompliance remained at the lower scope and severity level of F, widespread with no actual harm with potential for more than minimal harm that was not immediate jeopardy.

Findings include:

a) First Incident 3/7/21.

R3's quarterly Minimum Data Set (MDS) dated 6/1/21, identified R3 had intact cognition and required supervision to complete activities of daily living (ADL)'S. R3's care plan dated 4/20/21, identified a diagnosis of dementia, decreased independence and need for assistance from staff to perform ADL's

A Resident Grievance Form dated 3/7/21, indicated registered nurse (RN)-A received a complaint from a staff member of staff being mean, using profanity and calling R3 a name. The form indicated R3 reported similar information to day shift NA's and remained consistent when interviewed by RN-A. The grievance further indicated a night shift licensed practical nurse (LPN) reported the complaint and R3's family member (FM) called and reported R3 had told her similar concerns. Immediate action by nurse indicated she interviewed R3 and sent messages to NA-A and NA-B asking for their input. Correlating text messages between RN-A and NA-A identified the following:

- A documented interview dated 3/7/21, at 7:09 a.m. identified RN-A stated to NA-A, "Hey. We have had a resident c/o [complain of] this

F 600

No other concerns (other than the concern regarding R2 and NA-B) were identified based on the staff interviews.

In order to go beyond interviews to identify any signs of potential physical abuse, on 7/14/21, a facility RN reviewed documentation of weekly skin assessments of R1, R2, R3, R4 from 3/7/21 through 7/12/21. This review did not identify any signs or concerns of physical abuse.

No concerns, other than the originally reported and substantiated concern regarding R1 and NA-A and potential concern reported but unsubstantiated regarding Rs and NA-B, were identified.

Care plan for R1, R2, R3, and R4 were updated with individualized interventions to address the risk factors identified that individually made these residents vulnerable. This process is subsequently detailed in the systematic change Resident Care Plans Updated.

NA-A was terminated on 6/25/21 when the facility substantiated the allegation that occurred on 6/18/21. From 7/19 to 7/31, charge nurses conducted care observations/audits of NA-B during worked shifts, with no concerns noted. Effective 7/20, the SSD and/or RNs began daily random audits of two residents, to identify any new incidents of potential abuse or neglect as subsequently detailed in the systematic change Daily Audits of Staff Care. Any concerns will be

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F 600

Continued From page 4

morning about the 2 small thin girls who were in her room last night being mean and using horrible language and called her a bitch. Please let me know ASAP if something happened, obviously this is unacceptable and we need to investigate the complaint further. Thanks." A second message indicated LPN also reported that before he left the same resident had complained about the girls working that night.

- Another interview identified NA-A stated to RN-A; "I would like to know who because I have been watching my language since I got talked to about it." The grievance was signed by the social services director (SSD)-A and the DON and indicated R3 agreed with the resolution, however, no resolution was identified. The allegation was not reported to the SA, nor were measures to protect the residents identified and implemented.

During interview on 7/12/21, at 12:11 a.m. RN-A stated the incident on 3/7/21, occurred on a weekend. The incident was reported to RN-A and she wrote up a grievance report. RN-A stated R3 had complained about the two girls swearing on the overnight shift and said there were only two girls working (NA-A and NA-B). RN-A interviewed R3 right away and R3 reported that the NA's had called her a B****. RN-A stated, "I suppose it could be considered verbal abuse." Further, RN-A had reported the incident to the DON that morning.

b) Second Incident 3/8/21.

R4's quarterly MDS dated 5/11/21, indicated R4 had severe cognitive impairment and required total assistance from staff for ADL's. R4's care plan dated 5/19/21, identified impaired cognition

F 600

immediately reported to the Administrator or the Director of Nursing who will report to the Administrator, and reports will be made to the SA as required. The daily audits will be conducted through August 12, 2021, at which time the facility□s QAPI committee will review findings, if any, and determine the need for further audits and frequency.

All staff completed additional training on vulnerable adults and reporting requirements subsequently detailed in the systematic change Supplemental Education on Vulnerable Adults. Specifically, Administrator and Director of Nursing have completed the Educare training for LTC: Vulnerable Adult on July 13,2021, completed the competency test and turned in the Certificate of completion to the RN staff development coordinator. NA-B completed this training and competency on 7/11/21.

The survey tags, regarding the DON, was reviewed under the Essentia-wide process of Just Culture on 8/11/21. This process is intended to provide an objective guide in identifying the cause and suggested corrective steps for negative outcomes. This was an educational approach the DON participated in to continue the DON□s education and training.

A change in Administrator occurred on 7/28/21.

On 7/12/21, as part of the IJ removal plan, the facility revised the Resident

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	245512	A. BUILDING ______ B. WING ______	C 07/15/2021

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FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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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and impaired mobility and directed staff to assist with ADL's.

A Resident Grievance Form dated 3/8/21, indicated NA-C reported to the DON via a handwritten note the following: "I want to inform you about the incidents that happened this weekend. On Saturday night 3/6, [NA-A and NA-B] were in [R4 and R3]'s room while I was helping them get ready for bed. Both girls were making inappropriate jokes, swearing and being rough with both residents." The form indicated the DON had spoken with R3 and R3 stated he did not hear anything. R4 did not remember the incident and did not comment. The grievance was signed by SSD-A and the DON and indicated R3 agreed with the resolution, however, no resolution was identified. The allegation was not reported to the SA, nor were measures to protect the residents identified or implemented.

c) Third Incident 4/5/21.

A Resident Grievance Form dated 4/5/21, indicated NA-D reported via e-mail to the DON and the administrator on 4/5/21, at 11:39 p.m. " I am sorry to be sending you this e-mail so late in the evening but I just got home from the facility working my scheduled shift from 2:00 p.m. until 11:30 p.m. and I can't sleep with what happened between another staff and a resident." NA-A and NA-D had gone into R3 and R4's room to assist them with p.m. cares and get into bed for the night. During the cares R3 had made some comments to NA-A. NA-D indicated not remembering all of the details but shortly after NA-A told R3 to "shut the F*** up." Then while assisting R4, told him in an upset tone that she was sick of both residents being mean to her

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Protection/Vulnerable Adult policy and procedure to reflect the federal reporting and protection requirements. The updated policy includes reporting to the Administrator and State Agency immediately (no later than 2 hours after being aware of the allegation of abuse or neglect) for all the allegations of potential resident abuse. The policy further states that the facility will ensure the alleged perpetrator is notified of the investigatory suspension and removed from the facility pending outcome of the investigation. This corrective action is subsequently detailed in the systemic change Revisions Facility□s Resident Protection / Vulnerable Adult Policy and Procedure and Staff Education.
Specific revisions to the policy include:
1) A procedure for allegations of abuse by staff, specifically the requirement that the alleged perpetrator is staff, assure that the alleged perpetrator is notified of the investigatory suspension, and remove from the facility pending outcome of the investigation.
2) The inclusion of federal regulations on required time frames for reporting suspected abuse. The policy now states: immediately or as soon as possible, report to Administrator & OHFC for serious bodily injury or allegations of abuse, no later than 2 hours of forming the suspicion or being notified of an allegation and within 24 hours of forming the suspicion or being notified of an allegation if the suspicion or allegation does not involve abuse or did not result in serious bodily injury.

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F 600	Continued From page 6 when she was only trying to help them. NA-D wrote, "I'm bringing this to your attention because as a mandated reported it's my responsibility to notify you regarding a vulnerable adult being mistreated with verbal attacks." The e-mail further identified several other staff members who had witnessed similar actions by NA-A. The grievance was signed by the SSD-B and the DON and indicated R3 agreed with the resolution, however, no resolution was identified. The allegation was not reported to the SA, nor were measures to protect the residents identified or implemented. d) Fourth Incident 4/5/21. R2's quarterly MDS dated 5/4/21, indicated R2 had moderate cognitive impairment and required extensive assistance from two staff for ADL's. R2's care plan dated 5/13/21, identified impaired mobility related to weakness and pain and directed staff to assist with bed mobility and transfers. R2's progress note dated 3/7/21, indicated R2 complained of pain and when asked what staff could do he began yelling at staff. Later R2 indicated he had not slept all night and when questioned why he did not say anything replied, "because everyone gets sassy with me if I do." A second Resident Grievance Form dated 4/5/21, identified R2 stated there was inappropriate verbal comments and behaviors from NA-A. The interview with R2 stated he was not sure if NA-A swore of not but stated NA-A pushes their buttons. Interviews with a staff member identified NA-A was short and rude with residents.	F 600	3) The inclusion of a process for interviewing other staff or residents who may have knowledge of abuse: a. The investigation will include, using Just Culture Principles from Essentia Health: i. Review all documents which may include: the medical record, assignments, care plan, all documentation, and employee personnel record(s). ii. Review of any electronic surveillance, if applicable. iii. Interviews of staff, residents, volunteers, and family members, as appropriate The facility has updated its grievance policy and form updated on 7/14/21, to include an immediate review for potential abuse or neglect. Residents and/or representatives were educated on how to report grievances or concerns about resident care, via the weekly facility newsletter on 7/15/21, with staff training on 8/4/21 and 8/5/21. The SSD and/or RN will provide ongoing education to residents and/or representatives during scheduled care conferences on the grievance procedure and Resident Bill of Rights. This corrective action is subsequently detailed in the systemic change Revisions to Facility Grievance Policy/Form and Reporting Education. How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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During interview on 7/12/21, at 11:39 a.m. R2 stated NA-A was short tempered and had a "bad mouth." R2 stated NA-A used the F word and said "I didn't like her mouth and she was so impatient." R2 stated "Oh, she's got a bad mouth, but I didn't want to make any trouble."

c) Fifth Incident 6/18/21.

R1's significant change MDS dated 6/16/21, identified severe cognitive impairment and required assistance of two staff for ADL's and was incontinent of bowel and bladder. R1's care plan dated 7/6/21, identified diagnoses of Alzheimer's, impaired mobility and required staff to assist with all ADL's.

A Resident Grievance Form dated 6/18/21, indicated LPN-A and NA-E reported NA-A using inappropriate language. The form indicated on Saturday 6/19/21, a text message was sent from RN-B to the DON and indicated: "FYI, issues with [NA-A] again last night. [LPN-A] has statements from two NA's who witnessed her behavior and form under my door to review concerns about [NA-A] working tonight." An untitled undated document indicated during the evening of 6/18/21, NA-E and NA-F were assisting R1 to wash up for the evening. R1 had been incontinent and staff called NA-A to assist. NA-A entered the room and stood by the door and stated "Eeww...do I really need to help, this F****** stinks so bad." While providing care NA-A stated R1 "stinks like shit all the time, " and "why do you have so much F****** poop on you, this is ridiculous." NA-A also told R1, "shut the F*** up, you're not in F****** pain." LPN-A moved NA-A to a different wing of the building. During a meeting on 6/19/21, NA-A denied using foul language and

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R1 was unable to be interviewed due to his passing from end stage prognosis on 7/16/21. R2 was interviewed on 7/12/21 and relayed concerns with NA-A that were consistent with staff reports to MDH about NA-A during the survey. R3 and R4 were interviewed on 7/12/21 and did not raise concerns regarding verbal or other abuse during the interviews. All other residents (in addition to R2, R3, and R4) were interviewed on 7/12/21 and 7/13/21 did not raise concerns regarding verbal or other abuse during the interviews.

On 7/12 and 7/13, all nursing home staff were interviewed and asked to identify any concerns of potential resident abuse. A potential concern was identified regarding R2 and NA-B. This concern was immediately reported to the Administrator and SA on 7/14/21. MDH reviewed this report and closed it on 7/16/21. This concern was not substantiated but to ensure nothing from the initial investigation was missed, from 7/19 to 7/31, charge nurses conducted care observations/audits of NA-B during her worked shifts, with no concerns noted. No other concerns (other than concern regarding R2 and NA-B) were identified based on the staff interviews.

In order to go beyond interviews to identify any signs of potential physical abuse, on 7/14/21, a facility RN reviewed documentation of weekly skin assessments of R1, R2, R3, R4 from 3/7/21 through 7/12/21. This review did

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requested to work on another wing and stated she was burnt out from the South wing. The report indicated NA-A was terminated on 6/25/21.

During interview on 7/12/21, at 11:16 a.m. the DON stated prior to the incident on 6/18/21, there had been previous concerns about NA-A. The DON identified the allegation by another staff member regarding R2 and R4 and stated R2 had not taken offense to it. The DON stated R2 knew NA-A was in trouble and tried to cover for her. NA-A had been educated about her swearing and was told if it continued she would be terminated. The DON took care of the issue in a grievance form and R2 "wasn't worried about it." The incidents were not reported to the SA but knew it was important and that's why a grievance report was filed. The DON stated after the incident regarding R1, the LPN on duty moved NA-A to another unit and LPN-A had not notified her or the administrator but notified the oncoming RN the next morning. Further, LPN-A should have notified the DON right away and then would have sent NA-A home and notified the administrator. The DON stated she started the grievance process on 6/21/21, because she was notified the grievance had been placed under her door and she was supposed to investigate it.

During interview on 7/12/21, at 11:49 a.m. RN-B stated the morning following the incident with NA-A and R1, LPN-A reported there were some issues and she had written up NA-A and put it under the DON's door. RN-B stated she contacted the DON and told her their had been some issues and NA-A was removed from the schedule. RN-B stated she did not remember if she had been told the specific information about the incident but felt like it was something the DON

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not identify any signs or concerns of physical abuse.

No concerns, other than the originally reported and substantiated concern regarding R1 and NA-A and potential concern reported but unsubstantiated regarding R2 and NA-B, were identified.

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

Facility, with assistance of outside legal counsel review, has implemented the following systemic changes/ measures to ensure the deficient practice will not recur:

Daily Audits of Staff Care: Effective 7/20, the Social Service Designee (SSD) implemented daily random audits (by observation and interviews) of two residents, to identify any new incidents of potential abuse or neglect. The DON and RN conducts audits by observation and interviews when Social Service Designee is absent.

Any concerns will be immediately reported to the Administrator or the Director of Nursing who will report to the Administrator, and reports will be made to the SA as required by law. These daily audits of staff care will be conducted through August 12, at which time the facility□s QAPI committee will review findings, if any, and determine the need for further audits and frequency.

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F 600	Continued From page 9 needed to know about. RN-B stated LPN-A told her whatever NA-A had said to R1 made the other two NA's so upset they were in tears. RN-B was aware of previous concerns with NA-A about her behaviors and not being appropriate. When interviewed on 7/12/21, at 12:24 p.m. the DON stated the incident with R3 was not reported to the SA as it was handled as a grievance. The DON had not thought about it as a reportable incident but stated, "it is abuse, I took it seriously, that's why a grievance was completed." The DON stated each of the incidents identified as grievances should have been reported to the SA and said she thought they were covering it by filing a grievance. On 7/12/21, at 1:35 p.m. the administrator and DON were interviewed. The administrator stated the incidents handled as grievances fit the definition of abuse and should have been reported and investigated. The administrator was not immediately notified about the events but generally would ask if the resident was safe and then put the staff member on another wing or "out the door." The DON stated staff were not provided any extra supervision or suspended during any of the instances. Further, the facility had not completed any audits on resident cares to ensure safe cares. The DON stated following the last incident involving R1, NA-A had been suspended the next day and with the other incidents she had spoken with the residents. The DON stated there was no documented proof NA-B used inappropriate language with any of the residents. Further, the DON stated she had not interviewed other residents or staff to determine if ay other	F 600	Implementation of First Care Vulnerable Adult Template: On 7/14 the facility□s First Care Vulnerable Adult Template was implemented in response to the survey. The DON and/or SSD (as applicable) will utilize the facility□s First Care Vulnerable Adult Template as a checklist to assure that applicable interviews of residents and staff who may have knowledge of abuse and neglect, as well as observations of care are included as part of the investigation of potential maltreatment. Revisions Facility□s Resident Protection / Vulnerable Adult Policy and Procedure and Staff Education: On 7/12/21, as part of the IJ removal plan, the Administrator and DON of the facility replaced the then current Essentia Health Resident Protection Plan/ Vulnerable Adult policy and procedure dated June 2017, with a revised Resident Protection/Vulnerable Adult policy and procedure, effective July 12, 2021, to better reflect current federal regulations. The QAPI committee will provide a final review and formal approval of updated policy on 8/12/21. This updated policy and procedure includes the following revisions to better reflect current federal reporting and protection requirements: (i) requirement that immediately or as soon as possible, reporting to the Administrator & OHFC for serious bodily injury or allegations of abuse, no later than 2 hours of forming the suspicion or being notified of an allegation and within 24 hours of forming the suspicion or being notified of an	

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residents had been subjected to verbal abuse by NA-A or NA-B.

On 7/13/21, at 8:37 a.m. LPN-B stated NA-A had an "attitude" since she started working at the facility. LPN-B stated NA-A swore all the time and was disrespectful to the residents and said she did a lot of "on the spot" education but it did not work. LPN-B stated she had reported it to the DON hoping she would do something about it. LPN-B stated multiple residents had complained about NA-A.

On 7/14/21, at 1:53 a.m. LPN-A stated when the incident occurred between NA-A and R1, she was the one first aware of the incident and wrote it up. LPN-A stated did not get the full story initially but NA-E and NA-F told her what happened. LPN-A stated she did not know exactly what to do but should have reported it to the DON right away. LPN-A only had concerns about NA-A and NA-B using inappropriate language. LPN-A had witnessed NA-A using inappropriate language prior to the incident with R1 but did not think it had been directed at a specific resident. LPN-A did not have any concerns about NA-B as the last time she had heard anything was about a year ago.

On 7/15/21, at 10:34 a.m. the administrator stated he relied on his leader in specific areas to stay abreast of policies and procedures and tried not to get too in depth with the details. Once something happened he was involved in terms of investigating, reporting and follow up. The administrator acknowledged he was not consistently notified immediately when incidents occurred in the facility.

F 600

allegation if the suspicion or allegation does not involve abuse or did not result in serious bodily injury; (ii) a requirement that if the alleged perpetrator is staff, assure that the alleged perpetrator is notified of the investigator suspension, and remove from the facility pending outcome of the investigation; and (iii) a requirement that any investigation conducted in response to an incident report also requires interviews with other staff or residents who may have knowledge or abuse. Staff were educated on this policy on 8/4/21 and 8/5/21. The new policy and procedure is available in the nurse□s stations and staff lounge for reference.

Revisions to Facility Grievance Policy/Form and Reporting Education: Effective 7/14, the facility grievance form has been reviewed and updated with clear directions to identify the grievance and immediately report the grievance to the SSD/DON/RN/or Administrator. The applicable person in charge must review the grievance form to determine if this grievance concerns potential abuse or neglect under the Resident Protection Plan/Vulnerable Adult policy and procedure, effective July 12, 2021, and if suspicions or abuse or neglect, will immediately notify the Administrator or Director of Nursing who will notify the Administrator.

Additionally, residents and/or representatives were educated on how to report grievances or concerns about

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F 600	Continued From page 11 The facility Essentia Health Fosston Vulnerable Adult Policy and Procedure dated June 2017, indicated Essentia Health Fosston should establish and enforce an ongoing abuse prevention plan. The plan should contain an assessment of the physical plant, environment and it's population identifying factors which may encourage or permit abuse and a statement of specific measures to be taken to minimize the risk of abuse. The policy identified Immediate as: "as soon as possible, but no later than 24 hours from the time initial knowledge that the incident occurred has been received." The policy indicated for long term care an electronic submission to the SA must be completed within 24 hours of the incident. - Section IV, Protection of Patient During Investigation indicated all patients, residents and clients will be protected from harm during the investigation. The policy lacked a procedure or steps to be taken to protect residents. - Section V, Reporting of Incident, Investigation and Facility Response to the Results Of the Investigation indicated reports would be made immediately to the director of long term care. The policy directed once a report was made internally, a team will convene to conduct the internal investigation. The internal team should interview staff involved in the incident, decide if a safety plan was needed and gather information related to past incidents by the alleged perpetrator. The policy did not include interviews with other staff or residents who may have knowledge of abuse. The IJ was removed on 7/15/21, at 10:55 a.m. when it could be verified through interview and document review the facility had updated their	F 600	resident care, via the weekly facility newsletter on 7/15/21, with staff training on 8/4/21 and 8/5/21. The SSD/RN will provide ongoing education to residents and/or representatives during scheduled care conferences on the grievance procedure and Resident Bill of Rights. Resident Care Plans Updated: On 7/15/21, the Social Services Designee reviewed and updated, as needed, all resident care plans in relation to vulnerability risk. The SSD will continue to complete resident risk observations to determine level of vulnerability on admission and quarterly. As changes are documented, care plans will be updated with the change as well as respective interventions. Supplemental Education on Vulnerable Adults: In addition to the existing annual training on vulnerable adults, all staff actively working, including the DON, nursing home staff and staff from other departments (housekeepers, supply chain, lab, therapy, maintenance) completed the assigned training Educare LTC: Vulnerable Adult and correlating competency evaluation by 8/10/21. New hires will also receive this supplemental annual training on a going forward basis. Specifically, Administrator and Director of Nursing completed the Educare training for LTC: Vulnerable Adult on July 13,2021, successfully completed the competency test and turned in the Certificate of completion to the RN staff development coordinator. NA-B successfully completed	

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F 600	Continued From page 12 policy on reporting and protecting residents with allegations of abuse; completed a thorough investigation to ensure no other residents had abuse concerns, which included resident interviews and skin assessments of those residents that could not be interviewed; and ensured all staff were educated on the new abuse policy and expectations.	F 600	this training and competency on 7/11/21. Employees on FMLA will complete this prior to working a shift after they return from FMLA. In addition to the existing annual training on vulnerable adults, the Educare LTC vulnerable adult class will be assigned annually going forward. RN staff development coordinator will oversee and monitor all training for compliance. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Report Log: The facility□s SSD implemented the Grievance/ Reports Log on 8/6/21 to track any reports to the SA to ensure facility appropriately responds and investigates allegations of potential misconduct in accordance with the law and the facility□s updated policy on vulnerable adults and the grievance form process. Monthly Audit: Effective 8/1/21, the SSD will conduct a monthly audit of all grievance forms and SA investigative files to identify compliance to the revised Facility□s Grievance Policy/Form implemented on 7/14/21. The audit findings will be reviewed in the subsequent QAPI committee and QAPI will direct any necessary corrective action. These audits will continue for 6 months, at which time QAPI will determine if additional audits are necessary.	

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F 600	Continued From page 13	F 600	Timely Reporting/Vulnerable Adult Education Audit: in addition, the DON or designee will conduct random audits with employees working on all shifts to verify timely reporting and understanding of the Vulnerable Adult policy and procedure. The audit schedule will be: 3x/week x4 weeks and then weekly x4 weeks. Each audit will include 5 employees. Results will be reviewed at the monthly QAPI meetings. The QAPI committee will review findings and determine if additional auditing or corrective action is required. The date that each deficiency will be corrected. Compliance date will be 8/15/2021.	
F 607 SS=F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their abuse prohibition and prevention policy included the federal	F 607	F 607 Facility, with assistance of outside legal	8/15/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 14 requirements related to reporting, protection and investigation. This had potential to affect all 34 residents residing in the nursing home at the time of the survey. Findings include: The facility Essentia Health Fosston Vulnerable Adult Policy and Procedure dated June 2017, indicated Essentia Health Fosston should establish and enforce an ongoing abuse prevention plan. The plan should contain an assessment of the physical plant, environment and it's population identifying factors which may encourage or permit abuse and a statement of specific measures to be taken to minimize the risk of abuse. The policy identified Immediate as: "as soon as possible, but no later than 24 hours from the time initial knowledge that the incident occurred has been received." The policy indicated for long term care an electronic submission to the SA must be completed within 24 hours of the incident. - Section IV, Protection of Patient During Investigation indicated all patients, residents and clients will be protected from harm during the investigation. The policy lacked a procedure or steps to be taken to protect residents. - Section V, Reporting of Incident, Investigation and Facility Response to the Results Of the Investigation indicated reports would be made immediately to the director of long term care. The policy directed once a report was made internally, a team will convene to conduct the internal investigation. The internal team should interview staff involved in the incident, decide if a safety plan was needed and gather information related	F 607	counsel review, has implemented the following systemic changes/ measures to ensure the deficient practice will not recur: Revisions Facility□s Resident Protection / Vulnerable Adult Policy and Procedure and Staff Education: On 7/12/21, as part of the IJ removal plan, the Administrator and DON of the facility replaced the then current Essentia Health Resident Protection Plan/ Vulnerable Adult policy and procedure dated June 2017, with a revised Resident Protection/Vulnerable Adult policy and procedure, effective July 12, 2021, to better reflect current federal regulations. The QAPI committee will provide a final review and formal approval of updated policy on 8/12/21. This updated policy and procedure includes the following revisions to better reflect current federal reporting and protection requirements: (i) requirement that immediately or as soon as possible, reporting to the Administrator & OHFC for serious bodily injury or allegations of abuse, no later than 2 hours of forming the suspicion or being notified of an allegation and within 24 hours of forming the suspicion or being notified of an allegation if the suspicion or allegation does not involve abuse or did not result in serious bodily injury; (ii) a requirement that if the alleged perpetrator is staff, assure that the alleged perpetrator is notified of the investigator suspension, and remove from the facility pending outcome of the investigation; and (iii) a requirement that any investigation	

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	245512	A. BUILDING ______ B. WING ______	C 07/15/2021

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to past incidents by the alleged perpetrator. The policy did not include interviews with other staff or residents who may have knowledge of abuse.

During interview on 7/12/21, at 11:16 a.m. the director of nursing (DON) stated the policy directed staff to report to the administrator immediately if the incident was urgent but otherwise it was 24 hours.

At 1:35 p.m. the administrator stated the incidents fit the definition of abuse and should have been reported to the SA.

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conducted in response to an incident report also requires interviews with other staff or residents who may have knowledge or abuse.

Systematic change to ensure compliance with policy:
Implementation of First Care Vulnerable Adult Template: On 7/14 the facility□s First Care Vulnerable Adult Template was implemented in response to the survey. The DON and/or SSD (as applicable) will utilize the facility□s First Care Vulnerable Adult Template as a checklist to assure that applicable interviews of residents and staff who may have knowledge of abuse and neglect, as well as observations of care are included as part of the investigation of potential maltreatment.
Policy Education: Staff were educated on the revised policy on 8/4/21 and 8/5/21. The new policy and procedure is available in the nurse□s stations and staff lounge for reference.

Supplemental Education on Vulnerable Adults: In addition to the existing annual training on vulnerable adults, all staff actively working, including the DON, nursing home staff and staff from other departments (housekeepers, supply chain, lab, therapy, maintenance) completed the assigned training Educare LTC: Vulnerable Adult and correlating competency evaluation by 8/10/21. New hires will also receive this supplemental annual training on a going forward basis.

Monitoring/Metrics:

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F 607	Continued From page 16	F 607	Monthly Audit: Effective 8/1/21, the SSD will conduct a monthly audit of all grievance forms and SA investigative files to identify compliance to the revised Facility□s Grievance Policy/Form implemented on 7/14/21. The audit findings will be reviewed in the subsequent QAPI committee and QAPI will direct any necessary corrective action. These audits will continue for 6 months, at which time QAPI will determine if additional audits are necessary. Timely Reporting/Vulnerable Adult Education Audit: in addition, the DON or designee will conduct random audits with employees working on all shifts to verify timely reporting and understanding of the Vulnerable Adult policy and procedure. The audit schedule will be: 3x/week x4 weeks and then weekly x4 weeks. Each audit will include 5 employees. Results will be reviewed at the monthly QAPI meetings. The QAPI committee will review findings and determine if additional auditing or corrective action is required. Date of Compliance: 8/15/21	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		8/15/21

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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 report incidents of abuse to the administrator and State Agency (SA) for 3 of 3 residents (R3, R2, R4) and failed to report timely to the SA for 1 of 1 resident (R1) reviewed for abuse.

Findings include:

R3's quarterly Minimum Data Set (MDS) dated 6/1/21, indicated she had intact cognition and required supervision to complete activities of daily living (ADL)'s. R3's care plan dated 4/20/21, identified diagnosis of Alzheimer's and dementia. The care plan identified decreased independence and need for assistance from staff to perform

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Facility, with assistance of outside legal counsel review, has implemented the following systemic changes/ measures to ensure the deficient practice will not recur:

Revisions to Facility Grievance Policy/Form and Reporting Education:
Effective 7/14, the facility grievance form has been reviewed and updated with clear directions to identify the grievance and immediately report the grievance to the SSD/DON/RN/or Administrator. The applicable person in charge must review

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ADL's.

R2's quarterly MDS dated 5/4/21, indicated he was moderately cognitively impaired and required extensive assitance from two staff for ADL's. R2's care plan dated 5/13/21, identified impaired mobility related to weakness and pain and directed staff to assist with bed mobility and transfers.

R4's quarterly MDS dated 5/11/21, indicated he was severely cognitively impaired and required total assistance from staff for ADL's. R4's care plan dated 5/19/21, identified impaired cognition and impaired mobility and directed staff to assist with ADL's.

R1's significant change MDS dated 6/16/21, identified severe cognitive impairment, indicated she required assistance from two staff for ADL's and was incontinent of bowel and bladder. R1's care plan dated 7/6/21, identified a diagnosis of Alzheimer's and impaired mobility. The care plan directed staff to assist with all ADL's.

A facility Resident Grievance Form dated 3/7/21, indicated registered nurse (RN)-A received a complaint from a staff member of staff being mean, using profanity and calling R3 a name. The form indicated R3 reported similar information to day shift NA's and remained consistent when interviewed by RN-A. The grievance further indicated a night shift licensed practical nurse (LPN) reported the complaint and R3's family member (FM) called and reported R3 had told her similar concerns. Immediate action by the nurse indicated she interviewed R3 and sent messages to NA-A and NA-B asking for their input. Correlating text messages between RN-A and

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the grievance form to determine if this grievance concerns potential abuse or neglect under the Resident Protection Plan/Vulnerable Adult policy and procedure, effective July 12, 2021, and if suspicions or abuse or neglect, will immediately notify the Administrator or Director of Nursing who will notify the Administrator.

Additionally, residents and/or representatives were educated on how to report grievances or concerns about resident care, via the weekly facility newsletter on 7/15/21, with staff training on 8/4/21 and 8/5/21. The SSD/RN will provide ongoing education to residents and/or representatives during scheduled care conferences on the grievance procedure and Resident Bill of Rights. Implementation of First Care Vulnerable Adult Template: On 7/14 the facility□s First Care Vulnerable Adult Template was implemented in response to the survey. The DON and/or SSD (as applicable) will utilize the facility□s First Care Vulnerable Adult Template as a checklist to assure that applicable interviews of residents and staff who may have knowledge of abuse and neglect, as well as observations of care are included as part of the investigation of potential maltreatment. Monthly Audit: Effective 8/1/21, the SSD will conduct a monthly audit of all grievance forms and SA investigative files to identify compliance to the revised Facility□s Grievance Policy/Form implemented on 7/14/21. The audit findings will be reviewed in the

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NA-A identified the following: 3/7/21, at 7:09 a.m., From RN-A to NA-A; "Hey. We have had a resident c/o [complain of] this morning about the 2 small thin girls who were in her room last night being mean and using horrible language and called her a bitch."

A Resident Grievance Form dated 3/8/21, indicated NA-C reported in a handwritten note to the DON the following: "I want to inform you about the incidents that happened this weekend. On Saturday night 3/6, [NA-A and NA-B] were in [R4 and R3]'s room while I was helping them get ready for bed. Both girls were making inappropriate jokes, swearing and being 'rough' with both residents."

A facility Resident Grievance Form dated 4/5/21, indicated NA-D reported via e-mail to the DON and the administrator on 4/5/21, at 11:39 p.m.: "I am sorry to be sending you this e-mail so late in the evening but I just got home from the facility working my scheduled shift from 2:00 p.m. to 11:30 p.m. and I can't sleep with what happened between another staff and a resident." NA-A and NA-D had gone into R3 and R4's room to assist them with p.m. cares and into bed for the night. During the cares R3 had made some comments to NA-A. NA-D did not remember all of the details but shortly after NA-A told R3 to "shut the F*** up." Then while assisting R4, told him in an upset tone that she was sick of both residents being mean to her when she was only trying to help them.

A facility Resident Grievance Form dated 6/18/21, indicated licensed practical nurse (LPN)-A and NA-E reported NA-A using inappropriate language. The form indicated on Saturday

subsequent QAPI committee and QAPI will direct any necessary corrective action. These audits will continue for 6 months, at which time QAPI will determine if additional audits are necessary.

Date of Compliance: 8/15/21

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F 609	Continued From page 20 6/19/21, a text message was sent from RN-B to the DON and indicated: "FYI, issues with [NA-A] again last night. LPN-A has statements from two NA's who witnessed her behavior and form under my door to review concerns about [NA-A] working tonight." An untitled undated document indicated during the evening of 6/18/21, NA-E and NA-F were assisting R1 to wash up for the evening. R1 had been incontinent and staff called NA-A to assist. NA-A entered the room and stood by the door and stated "Eeww...do I really need to help, this F****** stinks so bad." While providing care NA-A stated R1 "stinks like shit all the time, " and "why do you have so much F****** poop on you, this is ridiculous." NA-A also told R1, "shut the F*** up, you're not in F****** pain." A report regarding the incident was submitted to the SA on 7/6/21, 18 days after the allegation was made. During interview on 7/12/21, at 12:11 a.m. RN-A stated the incident on 3/7/21, had occurred on a weekend. The incident was reported to her and she wrote up a grievance report. RN-A stated R3 had complained about the two girls swearing on the overnight shift and there were only two girls working (NA-A and NA-B). RN-A interviewed R3 right away and R3 reported the NA's had called her a B****. " RN-A stated she reported the incident to the director of nursing (DON) the same morning. During interview on 7/12/21, at 11:16 a.m. the DON said the incidents had not been reported to the SA but knew it was important and that's why a grievance report was filed. Further, she started the grievance process on 6/21/21, when she was notified the grievance had been placed under her	F 609		

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F 609	Continued From page 21	F 609		

door and was supposed to investigate it. The DON confirmed the report to the SA had not been made timely. At 12:24 p.m. the DON stated she had not thought about the incidents as reportable to the SA but said, "it is abuse, I took it seriously," that's why a grievance was completed. The DON stated each of the incidents should have been reported to the SA and she thought they were covering it by filing a grievance.

At 1:35 p.m. the administrator stated the incidents fit the definition of abuse and should have been reported to the SA.

On 7/15/21, at 10:34 a.m. the administrator stated he relied on his leader in specific areas to stay abreast of policies and procedures and tried not to get too in depth into the details. The administrator stated once something happened he was involved in terms of investigating, reporting and follow up. The administrator acknowledged he was not consistently notified immediately when incidents occurred in the facility.

The facility Essentia Health Fosston Vulnerable Adult Policy and Procedure dated June 2017, indicated Essentia Health Fosston should establish and enforce an ongoing abuse prevention plan. The plan shall contain an assessment of the physical plant, environment and it's population identifying factors which may encourage or permit abuse and a statement of specific measures to be taken to minimize the risk of abuse. The policy identified Immediate as: "as soon as possible, but no later than 24 hours from the time initial knowledge that the incident occurred has been received." The policy indicated for long term care an electronic submission to the

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F 609	Continued From page 22 SA must be completed within 24 hours of the incident.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate allegations of abuse and provide protection during investigation for 4 of 4 residents (R3, R4, R2, R1) reviewed for allegations of abuse. Findings include: A facility Resident Grievance Form dated 3/7/21, indicated registered nurse (RN)-A received a complaint from a staff member of staff being mean, using profanity and calling R3 a name. The form indicated R3 reported similar information to	F 610	F 610 Facility, with assistance of outside legal counsel review, has implemented the following systemic changes/ measures to ensure the deficient practice will not recur: Corrections: Revisions to Facility Grievance Policy/Form: Effective 7/14, the facility grievance form has been reviewed and updated with clear directions to identify the grievance and immediately report the	8/15/21

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F 610	Continued From page 23 day shift NA's and remained consistent when interviewed by RN-A. The grievance further indicated a night shift licensed practical nurse (LPN) reported the complaint and R3's family member (FM) called and reported R3 had told her similar concerns. Immediate action by nurse indicated she interviewed R3 and sent messages to NA-A and NA-B asking for their input. Correlating text messages between RN-A and NA-A identified the following: 3/7/21, at 7:09 a.m., From RN-A to NA-A; "Hey. We have had a resident c/o (complain of) this morning about the 2 small thin girls who were in her room last night being mean and using horrible language and called her a bitch." The report indicated NA-B stated NA-A and herself had been in R3's room twice that night, denied NA-A swearing at R3 and said R3 stated to them, "Goodnight Girls, Thank you." NA-A admitted she may have been swearing in the hallway but denied it being directed at the residents. Interview with R3 indicated she had been mixed up and confused during the interview. The grievance lacked interviews with other resident or staff who may have had further knowledge and did not identify observations of cares were completed to ensure apporpriate cares were received. Further, the grievance lacked evidence the residents were protected from further abuse, pending investigation. A Resident Grievance Form dated 3/8/21, indicated NA-C reported in a handwritten note to the DON the following: "I want to inform you about the incidents that happened this weekend. On Saturday night 3/6, [NA-A and NA-B] were in [R4 and R3]'s room while I was helping them get ready for bed. Both girls were making inappropriate jokes, swearing and being rough	F 610	grievance to the SSD/DON/RN/or Administrator. The applicable person in charge must review the grievance form to determine if this grievance concerns potential abuse or neglect under the Resident Protection Plan/Vulnerable Adult policy and procedure, effective July 12, 2021, and if suspicions or abuse or neglect, will immediately notify the Administrator or Director of Nursing who will notify the Administrator. Revisions Facility's Resident Protection / Vulnerable Adult Policy and Procedure: On 7/12/21, as part of the IJ removal plan, the Administrator and DON of the facility replaced the then current Essentia Health Resident Protection Plan/ Vulnerable Adult policy and procedure dated June 2017, with a revised Resident Protection/Vulnerable Adult policy and procedure, effective July 12, 2021, to better reflect current federal regulations. The QAPI committee will provide a final review and formal approval of updated policy on 8/12/21. This updated policy and procedure includes the following revisions to better reflect current federal reporting and protection requirements: (i) requirement that "immediately or as soon as possible, reporting to the Administrator & OHFC for serious bodily injury or allegations of abuse, no later than 2 hours of forming the suspicion or being notified of an allegation" and "within 24 hours of forming the suspicion or being notified of an allegation if the suspicion or allegation	

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with both residents." The form indicated an unidentified RN stated NA-B told her R2 was crabby when giving report. Another resident was interviewed and said she wanted to report an issue. The resident stated NA-A must have had something happen on the way to work, she was mad about everything and in a bad mood. The resident reported that NA-A,"she gets rough if she is crabby." NA-A was interviewed and stated she was trying to do her job by rolling them. The report lacked evidence NA-B was interviewed regarding the allegation. The grievance lacked interviews with other resident or staff who may have had further knowledge and did not identify observations of cares were completed to ensure apporpriate cares were received. Further, the grievance lacked evidence the residents were protected from further abuse, pending investigation.

A facility Resident Grievance Form dated 4/5/21, indicated NA-D reported via e-mail to the DON and the administrator on 4/5/21, at 11:39 p.m.: "I am sorry to be sending you this e-mail so late in the evening but I just got home from the facility working my scheduled shift from 2:00 p.m. - 11:30 p.m. and I can't sleep with what happened between another staff and a resident." NA-A and NA-D had gone into R3 and R4's room to assist them with p.m. cares and into bed for the night. During the cares R3 had made some comments to NA-A. NA-D indicated not remembering all of the details but shortly after NA-A told R3 to "shut the F*** up." Then while assisting R4, told him in an upset tone that she was sick of both residents being mean to her when she was only trying to help them. The report indicated NA-A "agrees to write a statement and bring it by in a.m." NA-A stated, "now what's going on, I have really tried to

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does not involve abuse or did not result in serious bodily injury"; (ii) a requirement that "if the alleged perpetrator is staff, assure that the alleged perpetrator is notified of the investigator suspension, and remove from the facility pending outcome of the investigation"; and (iii) a requirement that any investigation conducted in response to an incident report also requires interviews with other staff or residents who may have knowledge or abuse.

Systematic Change to ensure investigative steps are taken:
Implementation of First Care Vulnerable Adult Template: On 7/14 the facility's First Care Vulnerable Adult Template was implemented in response to the survey. The DON and/or SSD (as applicable) will utilize the facility's First Care Vulnerable Adult Template as a checklist to assure that applicable interviews of residents and staff who may have knowledge of abuse and neglect, as well as observations of care are included as part of the investigation of potential maltreatment.
Education on Grievance Policy and Form: Residents and/or representatives were educated on how to report grievances or concerns about resident care, via the weekly facility newsletter on 7/15/21, with staff training on 8/4/21 and 8/5/21. The SSD/RN will provide ongoing education to residents and/or representatives during scheduled care conferences on the grievance procedure and Resident Bill of Rights.
Education on Resident Protection /

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING ______ B. WING ______	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

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F 610 Continued From page 25

watch my mouth, you have talked to me before about it and I'm sick of being called to your office." The grievance lacked interviews with other resident or staff who may have had further knowledge and did not identify observations of cares were completed to ensure apporpriate cares were received. Further, the grievance lacked evidence the residents were protected from further abuse, pending investigation.

A facility Resident Grievance Form dated 6/18/21, indicated licensed practical nurse (LPN)-A and NA-E reported NA-A using inappropriate language. The form indicated on Saturday 6/19/21, a text message was sent from RN-B to the DON and indicated: "FYI, issues with [NA-A] again last night. LPN-A has statements from two NA's who witnessed her behavior and form under my door to review concerns about [NA-A] working tonight." An untitled undated document indicated during the evening of 6/18/21, NA-E and NA-F were assisting R1 to wash up for the evening. R1 had been incontinent and staff called NA-A to assist. NA-A entered the room and stood by the door and stated "Eeww...do I really need to help, this F****** stinks so bad." While providing care NA-A stated R1 "stinks like shit all the time, " and "why do you have so much F****** poop on you, this is ridiculous." NA-A also told R1, "shut the F*** up, you're not in F****** pain." The grievance lacked interviews with other resident or staff who may have had further knowledge and did not identify observations of cares were completed to ensure apporpriate cares were received. Further, the grievance lacked evidence the residents were protected from further abuse, pending investigation.

During interview on 7/12/21, at 1:35 p.m. the

F 610

Vulnerable Adult Policy and Procedure: Staff were educated on this policy on 8/4/21 and 8/5/21. The new policy and procedure is available in the nurse's stations and staff lounge for reference.
Monitoring/Metrics:
Report Log: The facility's SSD implemented the Grievance/ Reports Log on 8/6/21 to track any reports to the SA to ensure facility appropriately responds and investigates allegations of potential misconduct in accordance with the law and the facility's updated policy on vulnerable adults and the grievance form process.

Monthly Audit: Effective 8/1/21, the SSD will conduct a monthly audit of all grievance forms and SA investigative files to identify compliance to the revised Facility's Grievance Policy/Form implemented on 7/14/21. The audit findings will be reviewed in the subsequent QAPI committee and QAPI will direct any necessary corrective action. These audits will continue for 6 months, at which time QAPI will determine if additional audits are necessary.

Timely Reporting/Vulnerable Adult Education Audit: in addition, the DON or designee will conduct random audits with employees working on all shifts to verify timely reporting and understanding of the Vulnerable Adult policy and procedure. The audit schedule will be: 3x/week x4 weeks and then weekly x4 weeks. Each audit will include 5 employees. Results will be reviewed at the monthly QAPI

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F 610	Continued From page 26 administrator stated the incidents fit the definition of abuse and should have been thoroughly investigated. The DON, present during the interview stated following the last incident involving R1, NA-A had been suspended the next day and with the other incidents she had spoken with the residents, with the previous incidents the nursing assistants were allowed to continue working. The DON stated there was no documented proof NA-B had used inappropriate language with any of the residents so no action had been taken in regard to NA-B. The DON had not interviewed other residents or staff to determine if any other residents had been subjected to verbal abuse by NA-A or NA-B or completed observation of cares as part of the investigative process. The facility Essentia Health Fosston Vulnerable Adult Policy and Procedure dated June 2017, identified - Section V, Reporting of Incident, Investigation and Facility Response to the Results Of the Investigation indicated reports would be made immediately to the director of long term care. The policy directed once a report was made internally, a team will convene to conduct the internal investigation. The internal team should interview staff involved in the incident, decide if a safety plan was needed and gather information related to past incidents by the alleged perpetrator. The policy did not include interviews with other staff or residents who may have knowledge of abuse and/or observations of care.	F 610	meetings. The QAPI committee will review findings and determine if additional auditing or corrective action is required. Date of Compliance: 8/15/21	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 3, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Re: State Nursing Home Licensing Orders
Event ID: DJIC11

Dear Administrator:

The above facility was surveyed on July 12, 2021 through July 15, 2021 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, 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
	00461	A. BUILDING: ____ B. WING ____	C 07/15/2021

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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 7/12/21 - 7/15/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5512038C (MN74548) with a licensing order issued at MN St. Statute 626.557 Subd. 4A as a result of the investigation. The following complaint was found to be UNSUBSTANTIATED: H5513039C (MN74696). 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 surveyor's 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report incidents of abuse to the administrator and State Agency (SA) for 3 of 3 residents (R3, R2, R4) and failed to report timely to the SA for 1 of 1 resident (R1) reviewed for abuse. Findings include: R3's quarterly Minimum Data Set (MDS) dated 6/1/21, indicated she had intact cognition and	21995	Corrected	8/15/21

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required supervision to complete activities of daily living (ADL)'s. R3's care plan dated 4/20/21, identified diagnosis of Alzheimer's and dementia. The care plan identified decreased independence and need for assistance from staff to perform ADL's.

R2's quarterly MDS dated 5/4/21, indicated he was moderately cognitively impaired and required extensive assitance from two staff for ADL's. R2's care plan dated 5/13/21, identified impaired mobility related to weakness and pain and directed staff to assist with bed mobility and transfers.

R4's quarterly MDS dated 5/11/21, indicated he was severely cognitively impaired and required total assistance from staff for ADL's. R4's care plan dated 5/19/21, identified impaired cognition and impaired mobility and directed staff to assist with ADL's.

R1's significant change MDS dated 6/16/21, identified severe cognitive impairment, indicated she required assistance from two staff for ADL's and was incontinent of bowel and bladder. R1's care plan dated 7/6/21, identified a diagnosis of Alzheimer's and impaired mobility. The care plan directed staff to assist with all ADL's.

A facility Resident Grievance Form dated 3/7/21, indicated registered nurse (RN)-A received a complaint from a staff member of staff being mean, using profanity and calling R3 a name. The form indicated R3 reported similar information to day shift NA's and remained consistent when interviewed by RN-A. The grievance further indicated a night shift licensed practical nurse (LPN) reported the complaint and R3's family member (FM) called and reported R3 had told her

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21995	Continued From page 4	21995		

similar concerns. Immediate action by the nurse indicated she interviewed R3 and sent messages to NA-A and NA-B asking for their input. Correlating text messages between RN-A and NA-A identified the following: 3/7/21, at 7:09 a.m., From RN-A to NA-A; "Hey. We have had a resident c/o [complain of] this morning about the 2 small thin girls who were in her room last night being mean and using horrible language and called her a bitch."

A Resident Grievance Form dated 3/8/21, indicated NA-C reported in a handwritten note to the DON the following: "I want to inform you about the incidents that happened this weekend. On Saturday night 3/6, [NA-A and NA-B] were in [R4 and R3]'s room while I was helping them get ready for bed. Both girls were making inappropriate jokes, swearing and being 'rough' with both residents."

A facility Resident Grievance Form dated 4/5/21, indicated NA-D reported via e-mail to the DON and the administrator on 4/5/21, at 11:39 p.m.: "I am sorry to be sending you this e-mail so late in the evening but I just got home from the facility working my scheduled shift from 2:00 p.m. to 11:30 p.m. and I can't sleep with what happened between another staff and a resident." NA-A and NA-D had gone into R3 and R4's room to assist them with p.m. cares and into bed for the night. During the cares R3 had made some comments to NA-A. NA-D did not remember all of the details but shortly after NA-A told R3 to "shut the F*** up." Then while assisting R4, told him in an upset tone that she was sick of both residents being mean to her when she was only trying to help them.

A facility Resident Grievance Form dated 6/18/21,

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21995	Continued From page 5	21995		

indicated licensed practical nurse (LPN)-A and NA-E reported NA-A using inappropriate language. The form indicated on Saturday 6/19/21, a text message was sent from RN-B to the DON and indicated: "FYI, issues with [NA-A] again last night. LPN-A has statements from two NA's who witnessed her behavior and form under my door to review concerns about [NA-A] working tonight." An untitled undated document indicated during the evening of 6/18/21, NA-E and NA-F were assisting R1 to wash up for the evening. R1 had been incontinent and staff called NA-A to assist. NA-A entered the room and stood by the door and stated "Eeww...do I really need to help, this F****** stinks so bad." While providing care NA-A stated R1 "stinks like shit all the time, " and "why do you have so much F****** poop on you, this is ridiculous." NA-A also told R1, "shut the F*** up, you're not in F****** pain."

A report regarding the incident was submitted to the SA on 7/6/21, 18 days after the allegation was made.

During interview on 7/12/21, at 12:11 a.m. RN-A stated the incident on 3/7/21, had occurred on a weekend. The incident was reported to her and she wrote up a grievance report. RN-A stated R3 had complained about the two girls swearing on the overnight shift and there were only two girls working (NA-A and NA-B). RN-A interviewed R3 right away and R3 reported the NA's had called her a B****. " RN-A stated she reported the incident to the director of nursing (DON) the same morning.

During interview on 7/12/21, at 11:16 a.m. the DON said the incidents had not been reported to the SA but knew it was important and that's why a grievance report was filed. Further, she started

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21995	Continued From page 6	21995		

the grievance process on 6/21/21, when she was notified the grievance had been placed under her door and was supposed to investigate it. The DON confirmed the report to the SA had not been made timely. At 12:24 p.m. the DON stated she had not thought about the incidents as reportable to the SA but said, "it is abuse, I took it seriously," that's why a grievance was completed. The DON stated each of the incidents should have been reported to the SA and she thought they were covering it by filing a grievance.

At 1:35 p.m. the administrator stated the incidents fit the definition of abuse and should have been reported to the SA.

On 7/15/21, at 10:34 a.m. the administrator stated he relied on his leader in specific areas to stay abreast of policies and procedures and tried not to get too in depth into the details. The administrator stated once something happened he was involved in terms of investigating, reporting and follow up. The administrator acknowledged he was not consistently notified immediately when incidents occurred in the facility.

The facility Essentia Health Fosston Vulnerable Adult Policy and Procedure dated June 2017, indicated Essentia Health Fosston should establish and enforce an ongoing abuse prevention plan. The plan shall contain an assessment of the physical plant, environment and it's population identifying factors which may encourage or permit abuse and a statement of specific measures to be taken to minimize the risk of abuse. The policy identified Immediate as: "as soon as possible, but no later than 24 hours from the time initial knowledge that the incident occurred has been received." The policy indicated

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for long term care an electronic submission to the SA must be completed within 24 hours of the incident.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance.

TIME PERIOD FOR CORRECTION: 21 DAYS