Electronically delivered
January 28, 2021

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

RE: CCN: 245569
Cycle Start Date: January 12, 2021

Dear Administrator:

On January 12, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by April 12, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 12, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 28, 2021

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

Re: State Nursing Home Licensing Orders
Event ID: FGSF11

Dear Administrator:

The above facility was surveyed on January 12, 2021 through January 12, 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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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

Delivered Electronically

March 1, 2021

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

Subject: Halstad Living Center – Administrative review 2567 modification
CMS Certification Number (CCN): # 245569
Event ID: FGSF11

Dear Administrator:

This is a notice of an administrative review of a citation cited at tag F600 issued pursuant to the survey Event ID FGSF11, completed on January 12, 2021 as a part of MDH's Quality Assurance review. As a result of this review, it was determined the deficiency cited did not represent an immediate jeopardy situation, and confirmed you had already implemented corrective action to remove the deficient practice prior to our onsite survey.

Since we have determined this is not a valid example of a current deficient practice under this regulation, it will be removed from the Statement of Deficiencies.

A revised Statement of Deficiencies is attached.

Sincerely,

Susan Frericks, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-368-4467

cc: Office of Ombudsman for Long-Term Care
Brenda Fischer, Assistant Program Manager
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	133 FOURTH AVENUE EAST HALSTAD, MN 56548

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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 1/12/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that 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: H5569010C (MN#68962) with a licensing order issued at S#1995 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	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 ensure an alleged violation of staff to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse. Findings include: R1's admission Minimum Data Set (MDS) dated 11/17/20, identified R1 had severe cognitive impairment and had diagnoses which consisted	21995	Corrected.	2/11/21

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21995	Continued From page 2	21995		

of dementia, a hip fracture and Diabetes Mellitus. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion.

R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers, toileting, personal hygiene and dressing. The care plan indicated R1 had an alteration in thought processes and communication problem due to dementia and instructed staff to anticipate and meet R1's needs.

The facility's incident report indicated that on 1/9/21, at 10:45 p.m. staff stated LPN-A said to a resident quit being an "asshole". The allegation was reported to the SA on 1/10/21, at 7:10 p.m. 20 hours and 25 minutes after the incident occurred.

Review of the facility internal investigation handwritten notes revealed on 1/10/21, at 2:33 p.m. the director of nursing (DON) received a report from staff regarding allegations of staff to resident verbal abuse which occurred on 1/9/21. The DON spoke to nursing assistant (NA)-A on 1/10/21, who was working on 1/9/21, and she confirmed LPN-A told R1, "quit being an asshole". The DON spoke to NA-B on 1/10/21, who was also working on 1/9/21, and she confirmed LPN-A told R1, "quit being an asshole". The DON notified the administrator immediately and started the investigation.

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21995	Continued From page 3 On 1/12/21, at 12:59 p.m. during an interview, NA-A verified she worked on 1/9/21. NA-A stated she, NA-B and LPN-A were seated at the nurses station at around 10:45 p.m. when R1 who was in his wheelchair wheeled himself up to the nurses station. NA-A confirmed R1 had used foul language and LPN-A stated to R1, "quit being an asshole". NA-A confirmed it was a form of verbal abuse and should not have happened at all. NA-A confirmed she did not report the verbal abuse to anyone until the next day on 1/10/21, when she reported it to the charge nurse sometime that day. NA-A confirmed she was aware of the requirement to report it immediately and stated since LPN-A was her charge nurse on 1/9/21, she felt too intimidated to report it immediately. On 1/12/21, at 1:11 p.m. during an interview, NA-B stated she worked 1/9/21, from 6:00 pm. to 6:00 a.m. NA-B confirmed she, NA-A and LPN-A were seated at the nurses station around 10:45 p.m. when R1 wheeled up to the desk and used foul language when he was talking. NA-B could not recall exactly what R1 said. NA-B confirmed LPN-A stated to R1, "quit being an asshole". NA-B confirmed this was a form of verbal abuse. NA-B confirmed she did not report the verbal abuse immediately and believed NA-A had reported it immediately. NA-B confirmed she was aware all allegations of abuse were expected to be reported immediately. On 1/12/21, at 2:00 p.m. during an interview, licensed social worker (LSW) stated she received a phone call from the DON on 1/10/21, at around 6:00 p.m. and asked her to go to the facility to file a VA report due to an allegation of verbal abuse. LSW stated she was informed by the DON on 1/9/21, at 10:45 p.m. LPN-A told R1, "quit being	21995		

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21995	Continued From page 4	21995		

an asshole". LSW confirmed it was verbal, mental and emotional abuse and stated it should not be condoned. LSW confirmed the allegation of abuse occurred on 1/9/21, at 10:45 p.m. and was not reported to the SA until 1/10/21, at 7:10 p.m. The LSW stated all allegations of abuse were to be reported immediately.

On 1/12/21, at 2:10 p.m. during an interview with the DON, she stated she was called by the charge nurse working on 1/10/21, at 2:33 p.m. of an allegation of verbal abuse that occurred on 1/9/21, at 10:45 p.m. DON stated she spoke with NA-A and NA-B on 1/10/21, and both confirmed LPN-A stated to R1, "quit being an asshole". DON confirmed it was a form of verbal abuse and stated the facility had no tolerance for it. DON stated it was expected any form of abuse should never occur at the facility. DON stated she believed the facility had 24 hours to report it since the abuse did not result in physical or psychosocial harm. After review of the facility policy, DON confirmed the facility should have reported the allegation immediately or within two hours after the incident occurred. DON confirmed the allegation occurred on 1/9/21, at 10:45 p.m. and the facility did not report the allegation until 1/10/21, at 7:10 p.m. 20 hours and 25 minutes after the incident occurred.

On 1/12/21, at 3:03 p.m. during an interview with the administrator she stated she expected all allegations of abuse be reported immediately. Administrator confirmed she was informed of the allegation on 1/10/21, at around 2:30 p.m. and she went to the facility to assist with investigating further. The administrator stated she and the DON spoke with NA-A and NA-B on 1/10/21, to discuss further and confirmed it was a form of verbal abuse towards R1. The administrator

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21995	Continued From page 5 stated they provided education to NA-A and NA-B about the expectation to report all allegations of abuse immediately or within two hours after the allegation occurred. The administrator confirmed the allegation of verbal abuse was not reported timely as required. Review of the facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of resident Property revised 5/17, indicated abuse allegations were to reported per federal and state law. The policy stated the facility would ensure all alleged violations of abuse were to be reported immediately but not later than two hours after the allegation was made. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for reporting incident of abuse. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly reported to the DON, administrator and State Agency. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21995		

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F 000	INITIAL COMMENTS On 1/12/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5569010C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		2/11/21

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

Electronically Signed | 01/29/2021

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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HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

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F 600	Continued From page 1 §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 provide freedom from abuse for 1 of 3 residents (R1) reviewed for abuse when an incident of employee to resident verbal abuse occurred. Findings include: R1's admission Minimum Data Set (MDS) dated 11/17/20, identified R1 had severe cognitive impairment and had diagnoses which consisted of dementia, a hip fracture and Diabetes Mellitus. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion. R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers, toileting, personal hygiene and dressing. The care plan indicated R1 had an alteration in thought processes and communication problem due to dementia and instructed staff to anticipate and meet R1's needs. The facility's incident report indicated on 1/9/21, at 10:45 p.m. staff reported licensed practical	F 600	It is the policy of Halstad Living Center that all residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Halstad Living Center must not use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion. Based on interview and document review, Halstad Living Center failed to provide freedom from abuse for 1 of 3 residents for abuse when an incident of employee to resident verbal abuse occurred. LPN-A was immediately suspended upon notification of alleged verbal and emotional abuse and later terminated upon completion of investigation. NA-A and NA-B were provided immediate disciplinary action and education regarding timely mandated reporting of verbal and emotional abuse. During interview with NA-A and NA-B, DON/ADMIN asked if they had witnessed/observed any other/similar types of abuse from LPN-A to other residents. NA's state this was the first and only resident they had witnessed this type of abuse to. No other reports have been made regarding abuse to other residents All staff will finish completing annual Mandated Reporting and Vulnerable Adult & Abuse & Neglect Prevention Policy review and testing by February 5th, 2021 and complete further Mandated Reporting	

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	245569	A. BUILDING _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 2 nurse (LPN)-A stated to a resident quit being an "asshole". The facility internal investigation handwritten notes indicated on 1/10/21, at 2:33 p.m. the director of nursing (DON) received a report from staff regarding allegations of staff to resident verbal abuse which occurred on 1/9/21. The DON spoke to nursing assistant (NA)-A on 1/10/21, who was working on 1/9/21, and she confirmed the LPN-A told R1, "quit being an asshole". NA-A indicated she believed the LPN-A's attitude had changed over the past month and stated LPN-A had been more negative towards staff. The DON spoke to NA-B on 1/10/21, and she confirmed LPN-A stated to R1 on 1/9/21, "quit being an asshole". DON contacted LPN-A on 1/10/21, prior to the start of LPN-A's shift and informed her she was suspended until an investigation regarding resident verbal abuse was completed. Review of the facility termination letter dated 1/12/21, LPN-A was terminated effective 1/12/21, related to the following: verbal abuse to resident, not keeping residents safe or free of abuse, offensive behavior/ discrimination towards multiple employees, not performing tasks efficiently and in harmony with other employees, negative behavior about and towards residents and staff and inconsiderate, rude, impolite, offensive, obscene or vulgar treatment or language in front of residents and employees. On 1/12/21, at 12:59 p.m. during an interview, NA-A verified she worked on 1/9/21. NA-A stated she, NA-B and LPN-A were seated at the nurses station at around 10:45 p.m. when R1 who was in his wheelchair wheeled himself up to the nurses station. NA-A confirmed R1 had used foul	F 600	and Vulnerable Adult & Abuse & Neglect Prevention education by February 11th, 2021. Visual audits will be completed by DON or Designee and will review all State Agency reported abuse allegations to ensure the facility reported the allegation in a timely manner for 1 month, then 3 audits/month for 2 months, then monthly thereafter until 100% compliance is attained and maintained. Visual audits will then be completed randomly by DON or Designee on all reported abuse allegations thereafter to ensure continued compliance. In addition, the DON/Designee will conduct observation and interviews of staff/residents regarding care practices 3 times per month for 2 months, then monthly thereafter to ensure that any concern of abuse has been reported timely and investigations conducted thoroughly, until 100% compliance is attained and maintained. Audits will be reported to the Quality Assurance Committee and QAPI Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	

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F 600	Continued From page 3	F 600		

language and LPN-A stated to R1, "quit being an asshole". NA-A confirmed it was a form of verbal abuse and should not have happened at all. NA-A stated she had noticed a recent change in LPN-A's attitude and behavior and stated LPN-A's job was to care for R1 and not to treat him like that. NA-A stated this was R1's home and he deserved to be treated with dignity and respect.

On 1/12/21, at 1:11 p.m. during an interview, NA-B stated she worked 1/9/21, from 6:00 pm. to 6:00 a.m. NA-B confirmed she, NA-A and LPN-A were seated at the nurses station around 10:45 p.m. when R1 wheeled up to the desk and used foul language when he was talking. NA-B could not recall exactly what R1 said. NA-B confirmed LPN-A stated to R1, "quit being an asshole". NA-B confirmed this was a form of verbal abuse. NA-B stated LPN-A had become more negative recently and staff had noticed a recent change in her attitude.

On 1/12/21, at 2:00 p.m. during an interview, licensed social worker (LSW) stated she received a phone call from the DON on 1/10/21, at around 6:00 p.m. and asked her to go to the facility to file a VA report due to an allegation of verbal abuse. LSW stated she was informed by the DON on 1/9/21, at 10:45 p.m. that LPN-A told R1, "quit being an asshole". LSW confirmed it was verbal, mental and emotional abuse and stated it should not be condoned.

On 1/12/21, at 2:10 p.m. during an interview with the DON, she stated she was called by the charge nurse working on 1/10/21, at 2:33 p.m. of an allegation of verbal abuse that occurred on 1/9/21, at 10:45 p.m. DON stated she spoke with

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NA-A and NA-B on 1/10/21, and both confirmed LPN-A stated to R1, "quit being an asshole". NA-A informed DON she had noticed a recent change in AP's behavior and attitude. DON stated she contacted LPN-A on 1/10/21, prior to the start of her shift and informed her she was suspended pending further investigation. DON stated she and the administrator met with LPN-A at 11:00 a.m. on 1/12/21, and terminated LPN-A at that time. DON confirmed it was a form of verbal abuse and stated the facility had no tolerance for it. DON stated it was expected any form of abuse should never occur at the facility.

On 1/12/21, at 3:03 p.m. during an interview with the administrator she stated she expected all allegations of abuse be reported immediately. Administrator stated she was informed of the allegation on 1/10/21, at around 2:30 p.m. and she went to the facility to assist with investigating further. The administrator stated she and the DON spoke with NA-A and NA-B on 1/10/21, to discuss further and confirmed it was a form of verbal abuse towards R1. The administrator stated the DON called LPN-A and suspended her on 1/10/21, prior to her next shift pending the investigation. The administrator stated she and the DON met with LPN-A on 1/12/21, and terminated LPN-A at that time due to the verbal abuse that occurred and confirmed it was expected all residents were free from any abuse occurring in the facility.

Review of facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of resident Property revised 5/17, identified verbal abuse as the use of oral, written or gestured language that willfully inflicts disparaging or derogatory terms to residents or their families. The policy indicated

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F 600	Continued From page 5 each resident would be free from abuse in the facility and indicated abuse included verbal, mental, sexual, or physical abuse.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an alleged violation of staff	F 609	It is the policy of Halstad Living Center that to ensure that all alleged violations	2/11/21

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F 609	Continued From page 6 to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse. Findings include: R1's admission Minimum Data Set (MDS) dated 11/17/20, identified R1 had severe cognitive impairment and had diagnoses which consisted of dementia, a hip fracture and Diabetes Mellitus. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion. R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers, toileting, personal hygiene and dressing. The care plan indicated R1 had an alteration in thought processes and communication problem due to dementia and instructed staff to anticipate and meet R1's needs. The facility's incident report indicated that on 1/9/21, at 10:45 p.m. staff stated LPN-A said to a resident quit being an "asshole". The allegation was reported to the SA on 1/10/21, at 7:10 p.m. 20 hours and 25 minutes after the incident occurred. Review of the facility internal investigation	F 609	involving, abuse, neglect, exploitation or mistreatment 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 is serious injury; or not later than 24 hours if the events that cause that allegation do not involve abuse and do not results in serious bodily injury, to the administrator of the Halstad Living Center and other officials. . LPN-A was immediately suspended upon notification of alleged verbal and emotional abuse and later terminated upon completion of investigation. NA-A and NA-B were provided immediate disciplinary action and education regarding timely mandated reporting of verbal and emotional abuse. During interview with NA-A and NA-B, DON/ADMIN asked if they had witnessed/observed any other/similar types of abuse from LPN-A to other residents. NA's state this was the first and only resident they had witnessed this type of abuse to. No other reports have been made regarding abuse to other residents. All staff will finish completing annual Mandated Reporting and Vulnerable Adult & Abuse & Neglect Prevention Policy review and testing by February 5th, 2021 and complete further Mandated Reporting and Vulnerable Adult & Abuse & Neglect Prevention education by February 11th, 2021. Visual audits will be completed by DON or Designee and will review all State Agency reported abuse allegations to ensure the facility reported the allegation in a timely manner for 1 month, then 3 audits/month for 2 months, then monthly	

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F 609	Continued From page 7 handwritten notes revealed on 1/10/21, at 2:33 p.m. the director of nursing (DON) received a report from staff regarding allegations of staff to resident verbal abuse which occurred on 1/9/21. The DON spoke to nursing assistant (NA)-A on 1/10/21, who was working on 1/9/21, and she confirmed LPN-A told R1, "quit being an asshole". The DON spoke to NA-B on 1/10/21, who was also working on 1/9/21, and she confirmed LPN-A told R1, "quit being an asshole". The DON notified the administrator immediately and started the investigation. On 1/12/21, at 12:59 p.m. during an interview, NA-A verified she worked on 1/9/21. NA-A stated she, NA-B and LPN-A were seated at the nurses station at around 10:45 p.m. when R1 who was in his wheelchair wheeled himself up to the nurses station. NA-A confirmed R1 had used foul language and LPN-A stated to R1, "quit being an asshole". NA-A confirmed it was a form of verbal abuse and should not have happened at all. NA-A confirmed she did not report the verbal abuse to anyone until the next day on 1/10/21, when she reported it to the charge nurse sometime that day. NA-A confirmed she was aware of the requirement to report it immediately and stated since LPN-A was her charge nurse on 1/9/21, she felt too intimidated to report it immediately. On 1/12/21, at 1:11 p.m. during an interview, NA-B stated she worked 1/9/21, from 6:00 pm. to 6:00 a.m. NA-B confirmed she, NA-A and LPN-A were seated at the nurses station around 10:45 p.m. when R1 wheeled up to the desk and used foul language when he was talking. NA-B could not recall exactly what R1 said. NA-B confirmed LPN-A stated to R1, "quit being an asshole". NA-B confirmed this was a form of verbal abuse.	F 609	thereafter until 100% compliance is attained and maintained. Visual audits will then be completed randomly by DON or Designee on all reported abuse allegations thereafter to ensure continued compliance. In addition, the DON/Designee will conduct observation and interviews of staff/residents regarding care practices 3 times per month for 2 months, then monthly thereafter to ensure that any concern of abuse has been reported timely and investigations conducted thoroughly, until 100% compliance is attained and maintained. Audits will be reported to the Quality Assurance Committee and QAPI Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	

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NA-B confirmed she did not report the verbal abuse immediately and believed NA-A had reported it immediately. NA-B confirmed she was aware all allegations of abuse were expected to be reported immediately.

On 1/12/21, at 2:00 p.m. during an interview, licensed social worker (LSW) stated she received a phone call from the DON on 1/10/21, at around 6:00 p.m. and asked her to go to the facility to file a VA report due to an allegation of verbal abuse. LSW stated she was informed by the DON on 1/9/21, at 10:45 p.m. LPN-A told R1, "quit being an asshole". LSW confirmed it was verbal, mental and emotional abuse and stated it should not be condoned. LSW confirmed the allegation of abuse occurred on 1/9/21, at 10:45 p.m. and was not reported to the SA until 1/10/21, at 7:10 p.m. The LSW stated all allegations of abuse were to be reported immediately.

On 1/12/21, at 2:10 p.m. during an interview with the DON, she stated she was called by the charge nurse working on 1/10/21, at 2:33 p.m. of an allegation of verbal abuse that occurred on 1/9/21, at 10:45 p.m. DON stated she spoke with NA-A and NA-B on 1/10/21, and both confirmed LPN-A stated to R1, "quit being an asshole". DON confirmed it was a form of verbal abuse and stated the facility had no tolerance for it. DON stated it was expected any form of abuse should never occur at the facility. DON stated she believed the facility had 24 hours to report it since the abuse did not result in physical or psychosocial harm. After review of the facility policy, DON confirmed the facility should have reported the allegation immediately or within two hours after the incident occurred. DON confirmed the allegation occurred on 1/9/21, at 10:45 p.m.

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and the facility did not report the allegation until 1/10/21, at 7:10 p.m. 20 hours and 25 minutes after the incident occurred.

On 1/12/21, at 3:03 p.m. during an interview with the administrator she stated she expected all allegations of abuse be reported immediately. Administrator confirmed she was informed of the allegation on 1/10/21, at around 2:30 p.m. and she went to the facility to assist with investigating further. The administrator stated she and the DON spoke with NA-A and NA-B on 1/10/21, to discuss further and confirmed it was a form of verbal abuse towards R1. The administrator stated they provided education to NA-A and NA-B about the expectation to report all allegations of abuse immediately or within two hours after the allegation occurred. The administrator confirmed the allegation of verbal abuse was not reported timely as required.

Review of the facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of resident Property revised 5/17, indicated abuse allegations were to reported per federal and state law. The policy stated the facility would ensure all alleged violations of abuse were to be reported immediately but not later than two hours after the allegation was made.