Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 15, 2023

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

RE: CCN: 245569
Cycle Start Date: December 22, 2022

Dear Administrator:

On February 3, 2023, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 6, 2023

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

RE: CCN: 245569
Cycle Start Date: December 22, 2022

Dear Administrator:

On December 22, 2022, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 22, 2023 (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 June 22, 2023 (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

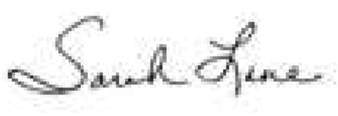
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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,



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January 6, 2023

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

Re: Event ID: VP0B11

Dear Administrator:

The above facility survey was completed on December 22, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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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 12/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/20/22, to 12/22/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H55696581C (MN00089156) The following complaint was found to be UNSUBSTANTIATED: H55696513C (MN00089154) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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	245569	A. BUILDING _____ B. WING _____	C 12/22/2022

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F 000	INITIAL COMMENTS On 12/20/22, to 12/22/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H55696581C (MN00089156) with a deficiency at F600. The following complaint was found to be UNSUBSTANTIATED: H55696513C (MN00089154) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		1/9/23

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

Electronically Signed | 01/09/2023

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

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to protect 1 of 3 residents (R1) from mental and emotional abuse by staff when two staff were found to be taunting, teasing and tickling a resident regularly despite visual signs and verbal communication the resident was upset/angry with their treatment of him during care. Findings include: R1's quarterly Minimum Data Set (MDS) dated 10/3/22, identified R1's cognition intact, no behaviors, and had diagnoses which included major depressive disorder, obesity, diabetes mellitus (DM), and moderately impaired vision. The MDS identified R1 required total assistance of one to two for most activities of daily living (ADLs) which included eating, personal hygiene, dressing, toileting, locomotion, transfers, and did not walk. MDS also identified R1 required extensive assistance of two for bed mobility. R1's care plan revised 6/18/21, identified R1 was at risk for injury related to vulnerable adult (VA) status with a goal R1 will be free from abuse and neglect every day. R1's care plan also identified R1 had a preferred name he wanted to be called. During an interview with the external complainant (EC) on 12/19/22, at 3:45 p.m. volunteered that	F 600	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident R1 was reassessed by the Director of Nursing Services, Administrator and Social Worker Designee on 12/20/2022 regarding concerns of abuse from resident's POA. The physician was notified promptly upon completion of the assessment. A thorough investigation was initiated and completed by the Social Worker Designee, Director of Nursing Services, and the facility Administrator. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Immediate education was provided to direct care nursing staff on 12/22/22. An in-service education program will be conducted by the Social Worker Designee with all staff addressing circumstances that require reporting including appropriate timeframes by 1/16/2023. 4. How the corrective action(s) will be	

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F 600	Continued From page 2 she was previously employed by the facility and had shared concerns about abuse pertaining to R1 by staff the end of October 2022. EC stated the director of nursing (DON) informed her to either quit, or she would be fired, adding that if EC kept reporting like she did the facility would not have any employees left. EC indicated the DON informed her, if there were no marks or signs of abuse, she could not do anything about it. EC stated she indicated to the DON it was a lot of emotional, mental abuse, and that cannot be seen. EC identified R1 was blind but was cognitively able to know what as going on around him and he could recognize voices. EC also indicated she had worked an evening shift with nursing assistant (NA)-A and NA-B and they had certain attitudes towards R1 and told EC there was no management to tell them what to do on the evening shift. EC indicated staff made fun of R1 because he was a bigger sized man and missing all fingers on left hand. EC stated NA-B called R1 names such as Big Daddy and P****. EC stated she requested the name calling be stopped but it continued. EC indicated she informed NA-B it was inappropriate to call him names he did not want to be called. EC stated NA-B informed her that was how they got along with R1, he would not say anything, and does not know who they are. EC stated she informed licensed practical nurse (LPN)-A about the interaction and concern, LPN-A wrote it down, and indicated she would pass it along to the DON in report. EC also stated R1 told the staff to stop calling him names, and R1 informed EC he felt they seemed to like to see him get mad. EC indicated she reported concerns many times during her employment at this facility to the DON. EC stated the DON wrote it down and indicated she would look into it.	F 600	monitored to ensure the practice will not recur: The Social Worker Designee, or other designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that no verbal, emotional, or physical abuse are identified, and if found they are properly investigated and reported to the appropriate people. Findings of this audit will be discussed with the Resident Council. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 600	Continued From page 3 During an interview on 12/20/22, at 10:40 a.m. R1 sat in his room by himself in wheelchair with door closed in silence. R1 stated the night shift give him a hard time on his name and do not treat his name right. R 1 stated, "They keep saying P****, P****, P**** in a funny voice." R1 indicated it bothered him and there was nothing he could say or do adding, "it hurts me, they are having fun, but I don't think it is fun at all." R1 added, "When they tickle my feet, it makes me want to hurt them back and if I could just get a hold of them, it would not be nice." R1 stated the staff giggle and make fun of him even when asked to stop. R1 indicated it was hurtful and had been going on for two years now. R1 indicated he told a staff nurse that had seen other staff do this to him, but she did not seem to care, and thought they were having fun. R1 indicated it usually happened when staff placed him back into bed and they laughed and got so much enjoyment out of doing it, that is what was so awful and upset him. R1 stated he told them to stop, he started to swear, and then it got worse, and they tickled him more, then laughed, and laughed more. R1 also stated there were usually two staff in the room together, a male and female when it happened which made him feel frustrated, angry, and alone. R1 indicated every once in while he wished he could just swing out at them, but he knew he would be in big trouble so held back. R1 stated he did not feel comfortable talking to any staff about this because the nurse did not seem to care and did not want to get anyone into trouble, so he kept it to himself. During a telephone interview on 12/20/22, at 1:24 p.m. with family member (F)-A indicated she had just talked to R1 on the telephone, and he told	F 600		

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F 600	Continued From page 4 her staff on the graveyard shift had been tickling his feet and his reaction was so full bodied, tried to get the staff to stop and they won't. FA stated obviously it is entertaining for some people that work there and that is very disturbing. FA also stated she had no leverage with his care and just beside herself with what had happened to R1. FA indicated R1 had gotten such good care at that facility. FA stated R1 did not want to get anyone fired from their job but she also stated it was totally disrespectful. During an interview on 12/20/22, at 2:37 p.m. social service designee (SSD) approached surveyor and stated she had just received a phone call from R1's family regarding concerns about the night staff tickling his feet for their own entertainment and the family indicated it was torture for him. SSD also stated she notified the ombudsman, DON, and administrator after 1:00 p.m. today. SSD verified she filed a vulnerable adult report and asked a registered nurse to assess resident for any injuries, none noted. SSD indicated she had not heard of any reports prior to this regarding the tickling of R1's feet. SSD stated she initiated the facility emotional distress/discomfort checks every shift for seven days. SSD stated she was on her way to R1's room to interview him and would remind him he had not gotten staff into trouble, the staff had gotten themselves in trouble. During a follow up interview on 12/21/22, at 10:43 a.m. SSD stated she talked with R1 in his room along with the DON on 12/19/22, and R1 made reference it had been a guy and a gal that most likely did not realize how ticklish his feet had been. SSD also stated R1 did not know the names of the staff, did not want to get anyone in	F 600		

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F 600	Continued From page 5 trouble, and wished he would have never said anything. SSD also stated she had just spoke with R1 briefly again this morning, and R1 denied any issues and mood was fine per him. SSD indicated she had interviewed three NAs and one more left to get a hold of and two staff nurses. SSD indicated no concerns were identified, however, during the interview with NA-B stated she might be the feet tickler when she applied lotion R1 stated he did not want it applied and yelled out when NA-A removed his socks. During an interview on 12/20/22, at 3:20 p.m. NA-A stated R1 was more confused and forgetful after he wakes up from sleeping. NA-A indicated R1 was able to verbalize if something was bothering him and "normally, we have a pretty good time, we joke a lot, it is all good in fun, and give each other shit." During an interview on 12/20/22, at 4:15 p.m. NA-F stated R1 was able to verbalize if something had bothered him. NA-F also stated earlier this summer, R1 complained some of the staff were not saying his name right and how it bothered him. NA-F indicated she had told only one person and that was RN-A but she was not sure if anything was done about it. RN-A was contacted but never returned phone call and was absent from work during survey. During an interview on 12/21/22, at 12:39 p.m. NA-G stated R1 was able to tell you if something bothered him, very blunt, and says what was on his mind. NA-G has heard NA-C call R1 Big Daddy and not sure who called him M*** M******** but R1 did say that both those names bothered him. NA-G stated she had told the DON over two	F 600		

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F 600	Continued From page 6 days ago and was told she would figure out who said it. NA-G indicated she did not confront NA-C about calling R1 Big Daddy and should have because NA-G knew better and R1 preferred to be called by his chosen name. NA-G stated those other names may be used in a joking manner but R1 had made it clear he does not like it. During an interview on 12/21/22, at 1:07 p.m. the DON stated staff are expected to listen to a resident's concerns, report it to charge nurse or myself, and just follow the chain of command. DON also stated the importance of addressing a complaint right away was to help protect the resident, and start an investigation. DON indicated on 12/5/22, an employee who was no longer with the facility reported to her, staff had called R1 P**** instead of what he wanted to be called. DON indicated she met with R1 and he reported that sometimes the staff called him P**** and he did not like to be called that but also did not want to get anyone in trouble because he liked it here. DON stated she placed a note in the staff communication book that indicated do not call residents by anything other than their name. DON identified she had worked a night shift on 12/13/22, asked R1 how things were going and he repeated the concern but did not identify who the staff was. DON then stated on 12/14/22, during a positive partners meeting (RNs, LPNs, and NAs) discussed R1 being called P*** and readdressed the concern. DON indicated she knew nothing about the tickling of his feet until she received a phone call from a family member on 12/19/22. DON stated she felt it was concerning and if it was true they want to fix it. DON stated staff are expected to treat residents the way they want to be treated, use proper interventions to help prevent staff from treating	F 600		

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	245569	A. BUILDING _____ B. WING _____	C 12/22/2022

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F 600	Continued From page 7 R1 in a way he does not want to be treated. DON stated staff are expected to communicate with R1 as to what cares they plan on starting in advance due to his poor vision and PVD. During a follow up interview on 12/22/22, at 12:00 p.m. DON stated the abuse policy regarding reporting was just posted in the communication right now. DON also stated on 12/20/22, she posted written communication regarding R1's concerns about being called P**** and tickling of his feet. DON verified the communication book is kept at the nurse's station and all nursing staff are expected to read updates daily prior to each shift prior to when they last worked. DON added that this expectation was important so that staff are up to date on new changes on how to care for residents, new happenings within the facility, and education provided. When asked how the facility new the staff were reading the communication book updates, the DON indicated staff do not initial that book daily and upon hire and annually they signed a job description they would keep abreast of happenings within the facility and residents. DON stated on 12/5/22, NA-D came to see her prior to leaving the facility and informed her R1 did not like being called P****. DON stated she then visited with R1 and he confirmed yes sometimes staff called him Peter and he did not like it and wanted to be called by his name. DON indicated R1 stated he did not want to identify staff and did not want anyone to get into trouble. DON stated she asked R1 to let her know if it continued to happen. DON verified she posted a note in the nursing communication book on 12/5/22, and no investigation was completed. DON indicated a positive partners committee meeting was held, discussed facility issues, and one that came up was a staff member NA-C said	F 600		

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F 600	Continued From page 8 to another unidentified staff member regarding R1, "do you want to come and help me get Big Daddy ready for bed." DON indicated the RN that worked that shift informed her of this incident and addressed it with NA-C. DON stated NA-C felt bad about it and no further follow up was completed. Facility employee communication book located at the central nursing station included the following documents posted by the DON: -On 12/5/22, [R1] has complaints that staff are calling him "P****" and he does not like it. Residents are to be called ONLY by their preferred name. Please report this if you see it happening. -On 12/14/22, Notes from the PP (Positive Partners) committee meeting: [R1] does not want to be called P**** or Big Daddy and if you hear anyone doing it SQUASH IT, PLEASE! -On 12/20/22, Regarding MDH (Minnesota Department of Health) and [R1]: Please call [R1] his preferred name, he does not like to be called P**** or any other name that staff have been calling him. This goes for all residents. We can not call them dear, honey, sweetheart, etc. Do not tickle resident's feet or anything else of that nature. [R1] has complained that staff tickle his feet and they do it "as pure entertainment" for themselves. RN (registered nurses)/licensed practical nurses (LPN): Please complete the "emotional assessment" under assessment tab. Monitor emotional status and report abnormalities to RN on call or social worker designee times 7 days. Also, [R1] reports that he doesn't get to choose his bedtime as staff tell him it's "now or	F 600		

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F 600	Continued From page 9 never". Bedtime choice is his right and there are always three or more staff that can help. During an interview on 12/22/22, at 11:34 a.m. NA-E stated R1 does not like lotion applied to his legs and feet. NA-E indicated R1 had complained about other staff tickling his feet and how he did not like it but did not mention names. NA-E also stated it was not reported to anyone because it seemed as though his feet were just sensitive and that did not seem reportable. NA-E verified she had heard him yell out when lotion was applied but had not witness staff treat him inappropriately. During an interview on 12/22/22, at 1:30 p.m. administrator stated R1 was interviewed on 12/20/22 in the early afternoon. Administrator indicated they had knowledge of a male nursing assistant that worked evening and/or night shift that may have been involved in the incident. Administrator stated she asked R1 if he felt safe at the facility and if he felt abused by staff, he denied both. Administrator then stated NA-A entered the room and came up to R1's bedside and administrator asked R1 "what about this guy"? Administrator verified R1 stated, "Oh that kid I like to give him bull shit!" Administrator identified that observation as a positive interaction with good rapport noted between R1 and NA-A. Administrator also stated she had never seen R1 upset with NA-A, made sure the resident was safe, and felt good about allowing all staff to care for R1. Administrator stated she did not stay and witness cares completed by NA-A, nor observed any cares being performed with R1 and staff. Administrator indicated there was only one nursing assistant they had been unable to interview and would not be allowed to care for R1	F 600		

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F 600	Continued From page 10 until that interview was completed. Administrator indicated no additional residents had been interviewed to determine if they felt safe or were experiencing abuse. Facility policy titled Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revised 1/2022, 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 also identified mental abuse as humiliation, harassment, threats of punishment or deprivation. The policy indicated each resident would be free from abuse in the facility and indicated abuse included verbal, mental, sexual, or physical abuse. Additionally, immediately upon receiving a report of alleged "abuse", the administrator, and or designee will coordinate delivery of appropriate medical and/or psychological care and attention to ensure safety and well-being for the vulnerable individual are utmost priority. Facility policy titled Dignity dated 3/2022, identified each resident shall be cared for in a manner that promoted and enhances quality of life, dignity, respect, and individuality. Staff should always speak respectfully to residents, including addressing the resident by his or her name of choice. Facility policy titled Employee Handbook undated identified staff expected behavior: -Treating employees, residents, and guests, with dignity, courtesy, and respect. -Keep the residents, and staff, and guests safe, and free from harm, abuse, including reporting	F 600		

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F 600	Continued From page 11 such incidences. -Refraining from behavior or conduct deemed offensive, undesirable, or which reflects badly on the facility. Facility prohibited conduct would be grounds for immediate termination, but not limited to such as: -Assaulting, threatening, intimidating, harassing or abuse of a resident, guest or and employee. -Making false, hostile, or disloyal statements about other staff, the facility, residents, or guests.	F 600		