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
April 5, 2021

Administrator
Mn Veterans Home - Luverne
1300 North Kniss, Po Box 539
Luverne, MN 56156

RE: CCN: 245631
Cycle Start Date: March 17, 2021

Dear Administrator:

On March 17, 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 June 17, 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 September 17, 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING ______ B. WING ______	C 03/17/2021

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MN VETERANS HOME - LUVERNE	**1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156**

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F 000	INITIAL COMMENTS On 3/17/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to NOT be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5631017C (MN67041) with a deficiency cited at F600, F609 and F610. H5631018C (MN70935) with a deficiency cited at F600 and F610. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	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- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		5/17/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/12/2021

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

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F 600

Continued From page 1

by:

Based on observation, interview, and document review, the facility failed to prevent sexual behaviors and implement interventions for 1 of 1 resident (R2) with known sexual behaviors who inappropriately touched R1 during 2 of 2 incidents of sexual abuse. Additionally, the facility failed to identify R1 was at increased risk for further abuse by another resident (R3) who also touched R1 inappropriately and had known sexual behaviors.

Findings include:

Review of the 11/6/20 at 11:37 a.m., report to the state agency (SA) identified the NA-A was walking up the hallway of the special care unit (SCU) and observed R2 sitting next to R1 with his hand in her shirt. R2 was unable to verbalize what he was doing and was removed from the area. NA-A noticed the registered nurse (RN) on duty. The residents were to remain separated from each other.

Review of the 11/10/21 at 11:37 a.m., investigation summary submitted to the SA identified NA-A was walking up the hallway and observed R2 sitting next to R1 with his hand in her shirt. Staff immediately separated the residents and notified the RN on duty. R2 was last seen in the hallway a few minutes prior to the incident. R2 had dementia and was unable to verbalize details of the incident. There were no prior incidents between the R1 and R2, all parties contacts were notified appropriately. There were no signs of distress from either resident following the incident. R2's care plan was updated to keep supervised interactions with female residents to remove resident from situations if inappropriate behavior occurs. R2 was to be offered

F 600

F600 □ Free from Abuse and Neglect

1. R2 was moved off the Special Care Unit (SCU) on 1/25/2021 and R3 was moved off of the SCU on 3/22/2021 in order to further protect R1. R1 has not been involved in any further similar events since the last event that occurred between R1 and R3 on 3/13/2021. All residents will be reviewed to determine if they are at a higher risk of receiving sexual abuse and/or determine if they have a history of sexual behaviors towards others. Those identified as being at a higher risk of receiving sexual abuse, which includes R1, will have a new vulnerability assessment completed and will be care planned to be observed for signs of sexual abuse. Residents identified to have a history of sexual behaviors towards others, including R2 and R3, will have a new vulnerability assessment completed and will be care planned to be observed for signs of sexual aggression or sexual behaviors towards others.

2. All residents have the potential to be affected.

3. Director of Nursing and Administrator reviewed policy titled Vulnerable Adult/Resident Protection Plan on 4/6/2021. Facility staff will be educated by the Administrator or Designee regarding the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specifically, staff will be educated regarding monitoring residents for signs of sexual

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F 600	Continued From page 2 distractions and activity when behaviors occurred. Review of the 1/23/21 at 2:03 p.m., report to the SA identified licensed practical nurse (LPN)-C was providing supervision in the SCU dining area. R1 was seated in a chair with an over-bed table in front of her and R2 was seated at a table adjacent to R1. LPN-C left the dining area to wake another resident for the noon meal. Upon LPN-C's return, R2 was sitting in front of R1 with his right hand on R1's knee and his left hand was reaching with his left hand was reaching for R1's breast. LPN-C was unsure if R2 actual contact occurred. Neither resident was upset at the time of the incident. R2 was immediately removed from the area. Both residents had no signs of distress and neither were able to be interviewed related to diagnoses of dementia. R2 was moved to another area in the facility for meals. R1 and R2 were to be kept separate from one another. Review of the 1/27/21 at 3:32 p.m., 5-day investigation report submitted to the SA identified both residents were separated at the time of the incident but could have been separated further. Neither resident had symptoms of distress following the incident, and neither were able to recall the event. Immediate interventions included immediate separation of R2 from R1. R2 was reassigned to sit in the solarium out of sight of R1 during meals. R2 was placed on frequent visual checks. R2's care plan and treatment administration record were revised to include scheduled documentation for staff visualize his location. The interdisciplinary team (IDT) met on 1/25/21, to discuss the incident and decided to move R2 from the SCU. R2 was placed on a unit separated from the SCU where only male residents resided. The report made no mention of	F 600	abuse and sexual behaviors towards others. 4. Audits will be conducted weekly for 4 weeks by the Administrator or Designee for 5 random residents to determine if the resident should be identified as being high risk for receiving sexual abuse or high risk of sexually abusing others. If any of the 5 residents are identified, resident□s care plan will be audited to ensure interventions are in place and determine if a vulnerability assessment may need to be completed. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 5/17/2021	

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F 600 Continued From page 3 F 600

any interventions of whether R1's care plan was reviewed and interventions added to prevent further abuse from occurring.

R2's 1/24/21, quarterly Minimum Data Set (MDS), identified he had mild cognitive deficits. R2 had physical behaviors directed towards others that occurred 1 to three days. R2 required extensive assistance of 1 staff to transfer. R2 was able to move independently on and off the unit with a wheelchair. R2's diagnoses included dementia with and without behavioral disturbance, muscle weakness, and a history of a benign brain tumor.

R2's 1/26/21, care plan identified R2 had impaired cognitive function related to a history of a benign brain tumor removal. R2 has a history of inappropriate sexual behaviors towards staff upon admission. Staff were to distract R2 with a walk, snacks, and other activities. Staff were to monitor R2 for behaviors and document every shift when R2 was sexually inappropriate, wandering or exit seeking. Staff were to supervise R2 around female residents and remove R2 if inappropriate behaviors occurred. R2 preferred to rise around 6:30 a.m., and staff were to keep R2's routine consistent.

Review of R2's progress notes identified on:
1) 12/20/20, R2 was sexually inappropriate and attempted to grab staff's breasts during assistance to transfer.
2) 1/23/21, R2 was sexually inappropriate towards staff and grabbed staff in the groin area during morning cares.
3) 1/28/21, R2 attempted to get into the SCU because his believed his wife was in the SCU.
4) 1/31/21 R2 was very "sexual during" during a.m. cares and at lunch grabbed a staff member's

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F 600	Continued From page 4	F 600		

buttocks.
5) 2/11/21, R2 put his hand between an NA's legs and made sexually inappropriate comments. Staff redirected R2.
6) 3/3/21, R2's behavior review charting identified R2 continued to have occasional sexual behaviors. R2 had 11 shifts with behavior documented over 5 weeks. Three shifts included sexual comments and grabbing at a staff member.

During an interview on 3/17/21 at 9:50 a.m. with RN-A identified R2 had poor cognition and insight. R2 used to reside on the Red wing prior to moving to the SCU. R2 had a history or being sexually inappropriate with staff. R2 also had a history of exit seeking and was moved to the SCU until he was sexually inappropriate with another resident. He was then moved to the Green Wing (all male) and has had less behaviors.

During an interview on 3/17/21 at 10:31 a.m. with NA-A identified R2 had a history of being sexually inappropriate with staff when staff helped him get up in the a.m. during cares and especially during toileting. R2 had a couple encounters with R1 where he was sexually inappropriate. One occurred a long time ago. NA-A was unable to recall the date but was working the day shift in the unit on the day it occurred. The night staff had gotten R2 up in the morning. NA-A had instructed the night staff to place R2 at a table and provide him with poker chips to keep him occupied while staff assisted resident with a.m. cares. R1 was in the last recliner on the right side of a bank of recliners in the common area. The night staff placed R2 on the opposite side of the recliners where R1 was sitting. As NA-A was coming down the hallway, she observed R2 sitting next to R1

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F 600	Continued From page 5 with his hand up R1's shirt. She separated the residents and reported the incident to the nurse immediately. After the incident staff were to supervise R2 when he was around other female residents. Staff were to also keep R1 separated from R2, and provide R2 with distractions, puzzles, and other activities. R2 had another more recent encounter with R1 during the noon meal. R2 was transferred to the Green wing following the incident as that was an all male unit. During an interview on 3/17/21 at 3:21 p.m., with the director of nursing (DON) identified R1 and R2 had a history of encounters involving sexual inappropriateness. On 11/6/21, R1 was left unattended by staff during while they were providing a.m. cares to other residents. On 1/23/21, R2 was left unattended in the SCU dining area. R2 approached R1 and was observed being sexually inappropriate. R2 was sexually inappropriate towards staff only prior to 11/6/21, and was not "on the radar" for sexual inappropriateness towards residents until 11/6/21. R2 was able to motivate independently in the unit and at times attempted to enter other resident's rooms. Staff were to redirect him and supervise him around female residents. Staff were trained to redirect him when he had behaviors. R2's second encounter was less than one minute, and the action took place outside of R1's clothing. Neither resident had signs of distress during or after the encounter. R2 was transferred to a separate male unit and had no attempts to return to the SCU or to find R1. Review of the 3/13/21, report to the SA identified R3 wheeled over to R1 who was sitting in recliner	F 600		

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F 600	Continued From page 6	F 600		

and placed one hand on her breast and appeared to be reaching to get under R1's shirt with other hand. Staff had taken another resident to the dining area and had been gone approximately 1 minute before returning to find R3 next to R1. Staff intervened and moved R3 to the dining area and initiated an activity to distract R3. R1 showed no signs of distress, pain, or injury. R1 had laughed and smiled when staff approached R1. Both residents lack capacity of consent/understanding.

R1's 3/3/21, quarterly MDS identified R1 had severe cognitive impairment. R1 had no behaviors during assessment period, required extensive assist with toileting, dressing, and bed mobility, total assistance with eating, and limited assistance with ambulation and transfers. R1 had diagnoses of Alzheimer's dementia and anxiety.

R1's undated care plan identified R1 had impaired cognitive functions and thought process related to dementia. R1 was not aware of place, time, or situation. R1 was not able to communicate her needs. On 11/6/20, an intervention was added that staff were to keep R2 away from R1. On 1/26/21, an intervention was added that identified staff were to keep R1 and R2 apart from each other and supervise any interaction between the two residents. On 3/15/21, an intervention was added for staff to keep R3 away from R1 and supervise any interactions between the two.

R1's progress notes identified following the sexual abuse perpetrated on R1 by R, staff were to keep R1 and R2 apart and provide appropriate supervision. Staff failed to do so, which resulted in a second sexual abuse event on 1/26/21. R1

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F 600	Continued From page 7	F 600		

was sexually assaulted on 3/13/21 a third time by another resident R3. There was no mention the facility identified R1 was at increased risk for abuse related to her dementia and required increased supervision to prevent further abuse from occurring, nor identified residents with known sexual behaviors towards staff were at increased risk to focus those behaviors towards other residents.

Review of R1's 3/1/21, vulnerability assessment identified she had cognitive impairment, physical limitation, and sensory/communication limitations. The assessment indicated to see care plan for maltreatment prevention plan. There was no mention she was at increased risk for abuse following the 11/6/21 incident.

R3's 1/25/21, quarterly MDS identified he had severe impairment. No behaviors were noted during the assessment period. R3 ate independently, was independent with locomotion once in his wheelchair, and required extensive assist with Activities of Daily Living (ADL). R3's diagnoses included traumatic brain injury (TBI), dementia, and anxiety.

R3's current, undated care plan identified R3 had impaired cognitive function related to dementia and impaired thought processes related to history of a motor vehicle accident that resulted in TBI. R3 also had mood affective disorder, sexual and anxiety disorders. R3 made impulsive decisions and comments that were sexually inappropriate. On 7/27/18, staff were to redirect R3 firmly if he was being sexually inappropriate and if behaviors continued, staff were to remove him to a safe place and re-approach later. Staff were to try different staff members or use 2 staff if needed to

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F 600	Continued From page 8	F 600		

lessen sexually inappropriate behaviors. On 3/13/21, an intervention was added that staff were to supervise interactions with female residents and remove R3 from situation if inappropriate behaviors occurred. Staff were to distract R3 with an activity in a separate area if behaviors were present. The facility failed to identify R3 was at risk for potential inappropriate behaviors with residents knowing he had the behaviors with staff in 2018.

Review of R3's 1/25/21, vulnerability assessment identified he had inappropriate sexual comments, cognitive impairment, physical limitations, sensory and communication limitation. He was assessed to have no indicators for increased risk of maltreatment towards other residents. There was no indication staff accurately assessed R2 for known sexual inappropriate behaviors beginning in 2018, and was therefore at increased risk for potential abuse of other residents.

R3's 3/17/21, staff Resident Care Sheet identified R3 had special needs as staff were to supervise all interactions with female residents. If sexual, staff were to redirect behavior or comments. There was no indication staff were alerted to ensure R3 was distanced and appropriately supervised when around female residents prior.

Review of R3's behavior notes from 1/1/21 through 3/16/21 identified the following. On:
1) 1/7/21, R3 made several attempts to grab at staff inappropriately and made sexual comments.
2) 1/10/21, R3 made sexual comments to staff during cares.
3) 1/13/21, R3 was making sexual comments to the staff during cares.

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MN VETERANS HOME - LUVERNE	**1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156**

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F 600	Continued From page 9 4) 1/15/21, R3 was making sexual comments to the staff. 5) 1/27/21, R3 had many sexual comments during the evening shift. 6) 2/1/21, R3 asked staff to come over so he could squeeze staff breast. 7) 2/2/21, R3 made sexual comments and statements towards staff during cares. 8) 2/3/21, R3 making sexual comments and grabbing at staff during cares. When staff no longer in R3 reach comments and advancements stopped. 9) 2/4/21, R3 made several sexually inappropriate comments towards staff. 10) 2/6/21, R3 made sexual remarks to staff during cares. 11) 2/22/21, R3 tried to touch staff inappropriately 2 times this shift. 12) 2/23/21, R3 had sexual comments and attempts to inappropriately touch staff 2 times. 13) 3/7/21, R3 called staff names and told staff to "pull down their pants..". 14) 3/13/21 (1:58 p.m.) R3 tried to grab a female resident's breast that day. 15) 3/13/21 (10:04 p.m.) R3 attempted to approach another female resident sexually. Staff redirected to another unit to watch TV. R3 would periodically ask "how about that little girl..." referring to a female resident. 16) 3/14/21, R3 was noted attempting to grab at a staff members breast during transfer. 17) 3/14/21, R3 made several sexual comments towards female staff through the evening shift. 18) 3/15/21, R3 noted to make frequent sexual comments to staff throughout shift. Interview on 3/17/21 at 9:15 a.m., with nursing assistant (NA)-A identified she was the one who witnessed the event between R1 and R3 that	F 600		

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F 600	Continued From page 10 occurred in the common area of the Special Care Unit (SCU). R1 was sitting in the recliner in the common area and R3 was sitting in his wheelchair parked by wall in front by R1. NA-A had taken another resident to the dining area and upon returning to the common area, witnessed R3 with his hand on top of R1's shirt over her breast. She cued R3 to stop as she walked towards them. R3 replied "she likes me". She confirmed R1 was nonverbal and smiled when she approached her to remove R3 from the area. A nurse, LPN-A was also in the area but had her back towards R1 and R3, as she was assisting another resident at the time. LPN-A did hear NA-A's verbal cues directed at R3 and assisted with intervening. The nurse instructed us to "keep a close eye" on R3 after that. NA-A revealed R3 had a history of making sexual comments or trying to touch staff however, R3 had never approached a resident before to her knowledge. She confirmed R3 was able to wheel his self around in his wheelchair. Observation on 3/17/21 at 9:35 a.m., of R1 identified she was sleeping in the recliner located in the common area on the SCU. No concerns were noted at that time. Observation on 3/17/21 at 10:05 a.m., of R3 identified he was sleeping while sitting in his wheelchair off to the side of the room in the dining area where an activity was taking place. No female residents were near. Staff were in the immediate area. Interview on 3/17/21 at 11:50 a.m., with licensed practical nurse (LPN)-A identified she had been in the common area on the SCU assisting another resident when R3 touched R1 in the breast area.	F 600		

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F 600	Continued From page 11	F 600		

She reports she had her back towards the two residents at the time but had heard NA-A comment to R3 "you cannot touch women like that" and turned to go assist with separating the two. She revealed the staff then kept R1 and R3 separated the rest of the weekend and staff kept R3 in eyesight.

Observation on 3/17/21 at 12:42 p.m. through 1:00 p.m., of the common area identified R3 was sleeping in a recliner. R1 was sitting at a small table behind R3. Staff were observed frequently walking through the common area for supervision of R3, however, staff were not consistently in the area.

Interview on 3/17/21 at 12:50 p.m., with NA-A identified the only resident on the SCU that had any sexual behaviors was R3. Staff supervise R3 unless he is resting in a stationary chair as he does not attempt to get out. During that time, staff could assist others and not be in the common area consistently.

Observation on 3/17/21 at 2:00 p.m., identified R1 was sleeping in a recliner in the common area and R3 was seated in a recliner with staff doing an one-to-one activity with R3.

Interview on 3/17/21 at 2:05 p.m., with registered nurse (RN)-B identified she was the evening supervisor on 3/13/21. Earlier in the day, R3 had an incident with R1 where he touched R1's breast. Later on that same day in the evening, an LPN had reported to her R3 was talking to R1 making comments of "that little girl.." and pointing at R1 so the staff moved him to another unit to watch a game on TV. R3 did not get close to R1 and confirmed the unit was always staffed with

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F 600	Continued From page 12 one person in the common area for constant supervision of R3 during the evening shift. RN-A confirmed that R3 was now to be appropriately supervised while he was around other residents to ensure R1's safety and any other resident's. Review of memo to staff dated 3/13/21, identified staff were to supervise all interactions with R3 and female residents. Staff are to remove R3 and report to the RN immediately if any inappropriate discussion or actions are witnessed. Interview on 3/17/21 at 4:17 p.m., with administrator revealed if a resident had identified sexual abuse he would expect interventions to be put into place to ensure the safety of the resident involved to prevent reoccurrence. Staff put interventions into place for R2. After the second incident of the same nature, R2 was moved off of the unit. He agreed the care plan had not been followed for R1 and R2 immediately preceding the second incident. The intervention identified they were not to be together. R1 and R2 had been left alone at the table and the second event occurred. He identified the third incident with R1 involving R3 "could not of been predicted" as the facility could not predict that kind of behavior. "The facility has policies in place to protect the residents and we do not want to move them off of the beneficial SCU unit if we do not need to". He stated R1 had no signs of fear and R3 was unable to recall the event. He disagreed that the facility did not protect R1 and prevent reoccurrence. "You cannot care plan every resident and predict every event". He agreed there was nothing added to R1's care plan after the first incident with R2, identifying she was already a victim of abuse and required increased supervision. Staff focused on R2 and R3's care	F 600		

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F 600	Continued From page 13	F 600		

plans. He agreed the facility should have prevented the second incident between R1 and R2 but felt there was no way to predict R3, even though staff documented R3 had known sexual behaviors to staff prior to the incident with R3. The Administrator identified the only resident on the SCU that had any inappropriate sexual behavior was R3.

Review of the 11/19/19, Vulnerable Adult and Resident Protection Plan policy identified sexual abuse was any non-consensual sexual contact with a resident. Willful meant deliberate actions of an individual, not whether an individual intended to inflict injury or harm. When any nursing home employee or volunteer became aware of abuse, they were to report it immediately to the supervisor or officer of the day. That staff was to immediately ensure the proper notifications were made to the facility leadership and state agency per state and federal requirements. Seven components were in place to prevent abuse. All staff were responsible for preventing abuse and were educated on how to report abuse. Staff were to assess, plan care and services, and monitor residents with needs and behaviors. Risk factors for abuse included a history of cognitive and sensory deficits, aggressive behaviors, behaviors such as entering other residents' rooms, wandering, and being socially inappropriate. Additional risk factors included communication disorders, nonverbal, and residents requiring heavy care or are totally dependent on staff. Appropriate interventions were to be identified and implemented for the resident involved and all other residents to prevent future occurrences. Residents were to be protected from the alleged offenders. Additional attention was to include consideration to provide

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F 600	Continued From page 14 safety for other residents as appropriate. If the resident could be at risk in the same environment, considerations to be made included changes in location. The facility failed to review the policy annually as required by federal regulation.	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	F 609		5/17/21

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F 609

Continued From page 15

by:
Based on interview and document review the facility failed to ensure 1 of 2 resident (R1)'s allegation of abuse was reported within 2 hours to the State Agency (SA).

Findings include

Review of the 11/6/20 at 11:37 a.m., report to the state agency (SA) identified at 7:00 a.m., the NA-A was walking up the hallway of the special care unit (SCU) and observed R2 sitting next to R1 with his hand in her shirt. R2 was unable to verbalize what he was doing and was removed from the area. NA-A notified the registered nurse (RN) on duty. The residents were to remain separated from each other.

Interview on 3/17/21 at 10:31 a.m., with NA-A identified on 11/6/20, she observed the interaction between R1 and R2. The charge nurse was notified immediately after the residents were separated.

Interview and document review, on 3/17/21 at 3:49 p.m., with the social worker (SW) identified she was asked to complete the investigation of the incident on 11/6/21 by either the administrator or the director of nursing (DON). She was notified at some time in the morning after she arrived to work. The SA report identified the incident occurred at 7:00 a.m. and indicted the SW was the person submitting the SA report. The SW identified she had worked on the investigation for quite some time before she reported the incident to the SA at 11:37 a.m. that day.

Interview and document review, on 3/17/21 at 4:01 p.m., with the DON identified she was

F 609

F609 □ Reporting of Alleged Violations

1. R2 was moved off the Special Care Unit (SCU) on 1/25/2021 and R3 was moved off the SCU on 3/22/2021 in order to further protect R1. R1 has not been involved in any further similar events since the last event that occurred between R1 and R3 on 3/13/2021. Facility has reported and will report other reportable incidents timely to OHFC.

2. All residents have the potential to be affected.

3. Director of Nursing and Administrator reviewed policy titled Vulnerable Adult/Resident Protection Plan on 4/6/2021. Facility staff will be educated by the Administrator or Designee regarding the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Facility staff will be educated by the Administrator or Designee regarding the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specifically, staff will be educated regarding reporting timelines for incidents of potential abuse.

4. Audits will be conducted weekly for 4 weeks by the Administrator or Designee for 10 random staff to ensure each staff member has a good understanding of the reporting timelines for incidents of potential abuse as well as the Vulnerable Adult/Resident Protection Plan Policy. Audit results will be reported to the Quality Assurance Committee for review at the

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F 609	Continued From page 16 unable to recall when she was notified of the incident on 11/6/21. The incident report provided identified she was notified at 12:25 p.m., after the SW reported the incident to the SA. The DON agreed the report was not made within 2 hours. Interview on 3/17/21 at 4:18 p.m., with the administrator identified he was not employed with the facility at the time of the incident but expected any allegation of abuse to be reported immediately but no later than 2 hours of notification for abuse. Review of the 11/19/19, Vulnerable Adult and Resident Protection Plan identified sexual abuse as nonconsensual sexual contact with a resident. The policy was to protect residents from maltreatment and comply with existing laws by including the seven-step approach to preventing abuse, including sexual abuse, and prevention. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation, or misappropriation shall immediately report the incident to their supervisor or the officer of the day. Staff were to report allegations of abuse immediately to the supervisor, who was to report allegations immediately to the administrator or designee. The administrator or designee with training and security password access for reporting was to report allegations of abuse to the SA within two hours.	F 609	next Quality Assurance meeting. 5. 5/17/2021	
F 610 SS=D	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:	F 610		5/17/21

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F 610	Continued From page 17 §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 observation, interview, and document review, the facility failed to take appropriate corrective action to prevent the subsequent abuse of 1 of 1 resident (R1) who was at high risk for further abuse by 2 of 2 residents (R2 and R3). Findings include: Review of the 11/6/20 at 11:37 a.m., report to the state agency (SA) identified the NA-A was walking up the hallway of the special care unit (SCU) and observed R2 sitting next to R1 with his hand in her shirt. R2 was unable to verbalize what he was doing and was removed from the area. NA-A noticed the registered nurse (RN) on duty. The residents were to remain separated from each other. Review of the 11/10/21 at 11:37 a.m., investigation summary submitted to the SA identified NA-A was walking up the hallway and observed R2 sitting next to R1 with his hand in	F 610	F610 □ Investigate/Prevent/Correct Alleged Violation 1. R2 was moved off the Special Care Unit (SCU) on 1/25/2021 and R3 was moved off of the SCU on 3/22/2021 in order to further protect R1. R1 has not been involved in any further similar events since the last event that occurred between R1 and R3 on 3/13/2021. All residents will be reviewed to determine if they are at a higher risk of receiving sexual abuse and/or determine if they have a history of sexual behaviors towards others. Those identified as being at a higher risk of receiving sexual abuse, which includes R1, will have a new vulnerability assessment completed and will be care planned to be observed for signs of sexual abuse. Residents identified to have a history of sexual behaviors towards others, including R2 and R3, will have a	

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F 610	Continued From page 18 her shirt. Staff immediately separated the residents and notified the RN on duty. R2 was last seen in the hallway a few minutes prior to the incident. R2 had dementia and was unable to verbalize details of the incident. There were no prior incidents between the R1 and R2, all parties contacts were notified appropriately. There were no signs of distress from either resident following the incident. R2's care plan was updated to keep supervised interactions with female residents to remove resident from situations if inappropriate behavior occurs. R2 was to be offered distractions and activity when behaviors occurred. Review of the 1/23/21 at 2:03 p.m., report to the SA identified licensed practical nurse (LPN)-C was providing supervision in the SCU dining area. R1 was seated in a chair with an over-bed table in front of her and R2 was seated at a table adjacent to R1. LPN-C left the dining area to wake another resident for the noon meal. Upon LPN-C's return, R2 was sitting in front of R1 with his right hand on R1's knee and his left hand was reaching with his left hand was reaching for R1's breast. LPN-C was unsure if R2 actual contact occurred. Neither resident was upset at the time of the incident. R2 was immediately removed from the area. Both residents had no signs of distress and neither were able to be interviewed related to diagnoses of dementia. R2 was moved to another area in the facility for meals. R1 and R2 were to be kept separate from one another. Review of the 1/27/21 at 3:32 p.m., 5-day investigation report submitted to the SA identified both residents were separated at the time of the incident but could have been separated further. Neither resident had symptoms of distress following the incident, and neither were able to	F 610	new vulnerability assessment completed and will be care planned to be observed for signs of sexual aggression or sexual behaviors towards others. 2. All residents have the potential to be affected. 3. Director of Nursing and Administrator reviewed policy titled Vulnerable Adult/Resident Protection Plan on 4/6/2021. Facility staff will be educated by the Administrator or Designee regarding the Vulnerable Adult/Resident Protection Plan Policy by 5/17/2021. Specifically, staff will be educated regarding monitoring residents for signs of sexual abuse and sexual behaviors towards others. 4. Audits will be conducted weekly for 4 weeks by the Administrator or Designee for 5 random residents to determine if the resident should be identified as being high risk for receiving sexual abuse or high risk of sexually abusing others. If any of the 5 residents are identified, resident□s care plan will be audited to ensure interventions are in place and determine if a vulnerability assessment may need to be completed. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 5/17/2021	

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F 610	Continued From page 19	F 610		

recall the event. Immediate interventions included immediate separation of R2 from R1. R2 was reassigned to sit in the solarium out of sight of R1 during meals. R2 was placed on frequent visual checks. R2's care plan and treatment administration record were revised to include scheduled documentation for staff visualize his location. The interdisciplinary team (IDT) met on 1/25/21, to discuss the incident and decided to move R2 from the SCU. R2 was placed on a unit separated from the SCU where only male residents resided. The report made no mention of any interventions of whether R1's care plan was reviewed and interventions added to prevent further abuse from occurring.

R2's 1/24/21, quarterly Minimum Data Set (MDS), identified he had mild cognitive deficits. R2 had physical behaviors directed towards others that occurred 1 to three days. R2 required extensive assistance of 1 staff to transfer. R2 was able to move independently on and off the unit with a wheelchair. R2's diagnoses included dementia with and without behavioral disturbance, muscle weakness, and a history of a benign brain tumor.

R2's 1/26/21, care plan identified R2 had impaired cognitive function related to a history of a benign brain tumor removal. R2 has a history of inappropriate sexual behaviors towards staff upon admission. Staff were to distract R2 with a walk, snacks, and other activities. Staff were to monitor R2 for behaviors and document every shift when R2 was sexually inappropriate, wandering or exit seeking. Staff were to supervise R2 around female residents and remove R2 if inappropriate behaviors occurred. R2 preferred to rise around 6:30 a.m., and staff were to keep R2's routine consistent.

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F 610	Continued From page 20	F 610		

Review of R2's progress notes identified on:
1) 12/20/20, R2 was sexually inappropriate and attempted to grab staff's breasts during assistance to transfer.
2) 1/23/21, R2 was sexually inappropriate towards staff and grabbed staff in the groin area during morning cares.
3) 1/28/21, R2 attempted to get into the SCU because his believed his wife was in the SCU.
4) 1/31/21 R2 was very "sexual during" during a.m. cares and at lunch grabbed a staff member's buttocks.
5) 2/11/21, R2 put his hand between an NA's legs and made sexually inappropriate comments. Staff redirected R2.
6) 3/3/21, R2's behavior review charting identified R2 continued to have occasional sexual behaviors. R2 had 11 shifts with behavior documented over 5 weeks. Three shifts included sexual comments and grabbing at a staff member.

During an interview on 3/17/21 at 9:50 a.m. with RN-A identified R2 had poor cognition and insight. R2 used to reside on the Red wing prior to moving to the SCU. R2 had a history or being sexually inappropriate with staff. R2 also had a history of exit seeking and was moved to the SCU until he was sexually inappropriate with another resident. He was then moved to the Green Wing (all male) and has had less behaviors.

During an interview on 3/17/21 at 10:31 a.m. with NA-A identified R2 had a history of being sexually inappropriate with staff when staff helped him get up in the a.m. during cares and especially during toileting. R2 had a couple encounters with R1 where he was sexually inappropriate. One

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	245631	A. BUILDING ______ B. WING ______	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	**1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156**

(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 610	Continued From page 21 occurred a long time ago. NA-A was unable to recall the date but was working the day shift in the unit on the day it occurred. The night staff had gotten R2 up in the morning. NA-A had instructed the night staff to place R2 at a table and provide him with poker chips to keep him occupied while staff assisted resident with a.m. cares. R1 was in the last recliner on the right side of a bank of recliners in the common area. The night staff placed R2 on the opposite side of the recliners where R1 was sitting. As NA-A was coming down the hallway, she observed R2 sitting next to R1 with his hand up R1's shirt. She separated the residents and reported the incident to the nurse immediately. After the incident staff were to supervise R2 when he was around other female residents. Staff were to also keep R1 separated from R2, and provide R2 with distractions, puzzles, and other activities. R2 had another more recent encounter with R1 during the noon meal. R2 was transferred to the Green wing following the incident as that was an all male unit. During an interview on 3/17/21 at 3:21 p.m., with the director of nursing (DON) identified R1 and R2 had a history of encounters involving sexual inappropriateness. On 11/6/21, R1 was left unattended by staff during while they were providing a.m. cares to other residents. On 1/23/21, R2 was left unattended in the SCU dining area. R2 approached R1 and was observed being sexually inappropriate. R2 was sexually inappropriate towards staff only prior to 11/6/21, and was not "on the radar" for sexual inappropriateness towards residents until 11/6/21. R2 was able to motivate independently in the unit and at times attempted to enter other resident's rooms. Staff were to redirect him and supervise him around female residents. Staff were trained	F 610		

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F 610	Continued From page 22 to redirect him when he had behaviors. R2's second encounter was less than one minute, and the action took place outside of R1's clothing. Neither resident had signs of distress during or after the encounter. R2 was transferred to a separate male unit and had no attempts to return to the SCU or to find R1. Review of the 3/13/21, report to the SA identified R3 wheeled over to R1 who was sitting in recliner and placed one hand on her breast and appeared to be reaching to get under R1's shirt with other hand. Staff had taken another resident to the dining area and had been gone approximately 1 minute before returning to find R3 next to R1. Staff intervened and moved R3 to the dining area and initiated an activity to distract R3. R1 showed no signs of distress, pain, or injury. R1 had laughed and smiled when staff approached R1. Both residents lack capacity of consent/understanding. R1's 3/3/21, quarterly MDS identified R1 had severe cognitive impairment. R1 had no behaviors during assessment period, required extensive assist with toileting, dressing, and bed mobility, total assistance with eating, and limited assistance with ambulation and transfers. R1 had diagnoses of Alzheimer's dementia and anxiety. R1's undated care plan identified R1 had impaired cognitive functions and thought process related to dementia. R1 was not aware of place, time, or situation. R1 was not able to communicate her needs. On 11/6/20, an intervention was added that staff were to keep R2 away from R1. On 1/26/21, an intervention was	F 610		

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F 610	Continued From page 23 added that identified staff were to keep R1 and R2 apart from each other and supervise any interaction between the two residents. On 3/15/21, an intervention was added for staff to keep R3 away from R1 and supervise any interactions between the two. R1's progress notes identified following the sexual abuse perpetrated on R1 by R, staff were to keep R1 and R2 apart and provide appropriate supervision. Staff failed to do so, which resulted in a second sexual abuse event on 1/26/21. R1 was sexually assaulted on 3/13/21 a third time by another resident R3. There was no mention the facility identified R1 was at increased risk for abuse related to her dementia and required increased supervision to prevent further abuse from occurring, nor identified residents with known sexual behaviors towards staff were at increased risk to focus those behaviors towards other residents. Review of R1's 3/1/21, vulnerability assessment identified she had cognitive impairment, physical limitation, and sensory/communication limitations. The assessment indicated to see care plan for maltreatment prevention plan. There was no mention she was at increased risk for abuse following the 11/6/21 incident. R3's 1/25/21, quarterly MDS identified he had severe impairment. No behaviors were noted during the assessment period. R3 ate independently, was independent with locomotion once in his wheelchair, and required extensive assist with Activities of Daily Living (ADL). R3's diagnoses included traumatic brain injury (TBI), dementia, and anxiety.	F 610		

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F 610	Continued From page 24	F 610		

R3's current, undated care plan identified R3 had impaired cognitive function related to dementia and impaired thought processes related to history of a motor vehicle accident that resulted in TBI. R3 also had mood affective disorder, sexual and anxiety disorders. R3 made impulsive decisions and comments that were sexually inappropriate. On 7/27/18, staff were to redirect R3 firmly if he was being sexually inappropriate and if behaviors continued, staff were to remove him to a safe place and re-approach later. Staff were to try different staff members or use 2 staff if needed to lessen sexually inappropriate behaviors. On 3/13/21, an intervention was added that staff were to supervise interactions with female residents and remove R3 from situation if inappropriate behaviors occurred. Staff were to distract R3 with an activity in a separate area if behaviors were present. The facility failed to identify R3 was at risk for potential inappropriate behaviors with residents knowing he had the behaviors with staff in 2018.

Review of R3's 1/25/21, vulnerability assessment identified he had inappropriate sexual comments, cognitive impairment, physical limitations, sensory and communication limitation. He was assessed to have no indicators for increased risk of maltreatment towards other residents. There was no indication staff accurately assessed R2 for known sexual inappropriate behaviors beginning in 2018, and was therefore at increased risk for potential abuse of other residents.

R3's 3/17/21, staff Resident Care Sheet identified R3 had special needs as staff were to supervise all interactions with female residents. If sexual, staff were to redirect behavior or comments.

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F 610	Continued From page 25 There was no indication staff were alerted to ensure R3 was distanced and appropriately supervised when around female residents prior. Review of R3's behavior notes from 1/1/21 through 3/16/21 identified the following. On: 1) 1/7/21, R3 made several attempts to grab at staff inappropriately and made sexual comments. 2) 1/10/21, R3 made sexual comments to staff during cares. 3) 1/13/21, R3 was making sexual comments to the staff during cares. 4) 1/15/21, R3 was making sexual comments to the staff. 5) 1/27/21, R3 had many sexual comments during the evening shift. 6) 2/1/21, R3 asked staff to come over so he could squeeze staff breast. 7) 2/2/21, R3 made sexual comments and statements towards staff during cares. 8) 2/3/21, R3 making sexual comments and grabbing at staff during cares. When staff no longer in R3 reach comments and advancements stopped. 9) 2/4/21, R3 made several sexually inappropriate comments towards staff. 10) 2/6/21, R3 made sexual remarks to staff during cares. 11) 2/22/21, R3 tried to touch staff inappropriately 2 times this shift. 12) 2/23/21, R3 had sexual comments and attempts to inappropriately touch staff 2 times. 13) 3/7/21, R3 called staff names and told staff to "pull down their pants..". 14) 3/13/21 (1:58 p.m.) R3 tried to grab a female resident's breast that day. 15) 3/13/21 (10:04 p.m.) R3 attempted to approach another female resident sexually. Staff redirected to another unit to watch TV. R3 would	F 610		

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F 610	Continued From page 26	F 610		

periodically ask "how about that little girl..." referring to a female resident.
16) 3/14/21, R3 was noted attempting to grab at a staff members breast during transfer.
17) 3/14/21, R3 made several sexual comments towards female staff through the evening shift.
18) 3/15/21, R3 noted to make frequent sexual comments to staff throughout shift.

Interview on 3/17/21 at 9:15 a.m., with nursing assistant (NA)-A identified she was the one who witnessed the event between R1 and R3 that occurred in the common area of the Special Care Unit (SCU). R1 was sitting in the recliner in the common area and R3 was sitting in his wheelchair parked by wall in front by R1. NA-A had taken another resident to the dining area and upon returning to the common area, witnessed R3 with his hand on top of R1's shirt over her breast. She cued R3 to stop as she walked towards them. R3 replied "she likes me". She confirmed R1 was nonverbal and smiled when she approached her to remove R3 from the area. A nurse, LPN-A was also in the area but had her back towards R1 and R3, as she was assisting another resident at the time. LPN-A did hear NA-A's verbal cues directed at R3 and assisted with intervening. The nurse instructed us to "keep a close eye" on R3 after that. NA-A revealed R3 had a history of making sexual comments or trying to touch staff however, R3 had never approached a resident before to her knowledge. She confirmed R3 was able to wheel his self around in his wheelchair.

Observation on 3/17/21 at 9:35 a.m., of R1 identified she was sleeping in the recliner located in the common area on the SCU. No concerns were noted at that time.

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F 610	Continued From page 27	F 610		

Observation on 3/17/21 at 10:05 a.m., of R3 identified he was sleeping while sitting in his wheelchair off to the side of the room in the dining area where an activity was taking place. No female residents were near. Staff were in the immediate area.

Interview on 3/17/21 at 11:50 a.m., with licensed practical nurse (LPN)-A identified she had been in the common area on the SCU assisting another resident when R3 touched R1 in the breast area. She reports she had her back towards the two residents at the time but had heard NA-A comment to R3 "you cannot touch women like that" and turned to go assist with separating the two. She revealed the staff then kept R1 and R3 separated the rest of the weekend and staff kept R3 in eyesight.

Observation on 3/17/21 at 12:42 p.m. through 1:00 p.m., of the common area identified R3 was sleeping in a recliner. R1 was sitting at a small table behind R3. Staff were observed frequently walking through the common area for supervision of R3, however, staff were not consistently in the area.

Interview on 3/17/21 at 12:50 p.m., with NA-A identified the only resident on the SCU that had any sexual behaviors was R3. Staff supervise R3 unless he is resting in a stationary chair as he does not attempt to get out. During that time, staff could assist others and not be in the common area consistently.

Observation on 3/17/21 at 2:00 p.m., identified R1 was sleeping in a recliner in the common area and R3 was seated in a recliner with staff doing

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F 610	Continued From page 28	F 610		

an one-to-one activity with R3.

Interview on 3/17/21 at 2:05 p.m., with registered nurse (RN)-B identified she was the evening supervisor on 3/13/21. Earlier in the day, R3 had an incident with R1 where he touched R1's breast. Later on that same day in the evening, an LPN had reported to her R3 was talking to R1 making comments of "that little girl.." and pointing at R1 so the staff moved him to another unit to watch a game on TV. R3 did not get close to R1 and confirmed the unit was always staffed with one person in the common area for constant supervision of R3 during the evening shift. RN-A confirmed that R3 was now to be appropriately supervised while he was around other residents to ensure R1's safety and any other resident's.

Review of memo to staff dated 3/13/21, identified staff were to supervise all interactions with R3 and female residents. Staff are to remove R3 and report to the RN immediately if any inappropriate discussion or actions are witnessed.

Interview on 3/17/21 at 4:17 p.m., with administrator revealed if a resident had identified sexual abuse he would expect interventions to be put into place to ensure the safety of the resident involved to prevent reoccurrence. Staff put interventions into place for R2. After the second incident of the same nature, R2 was moved off of the unit. He agreed the care plan had not been followed for R1 and R2 immediately preceding the second incident. The intervention identified they were not to be together. R1 and R2 had been left alone at the table and the second event occurred. He identified the third incident with R1 involving R3 "could not of been predicted" as the facility could not predict that kind of behavior.

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F 610	Continued From page 29 "The facility has policies in place to protect the residents and we do not want to move them off of the beneficial SCU unit if we do not need to". He stated R1 had no signs of fear and R3 was unable to recall the event. He disagreed that the facility did not protect R1 and prevent reoccurrence. "You cannot care plan every resident and predict every event". He agreed there was nothing added to R1's care plan after the first incident with R2, identifying she was already a victim of abuse and required increased supervision. Staff focused on R2 and R3's care plans. He agreed the facility should have prevented the second incident between R1 and R2 but felt there was no way to predict R3, even though staff documented R3 had known sexual behaviors to staff prior to the incident with R3. The Administrator identified the only resident on the SCU that had any inappropriate sexual behavior was R3. Review of the 11/19/19, Vulnerable Adult and Resident Protection Plan policy identified sexual abuse was any non-consensual sexual contact with a resident. Willful meant deliberate actions of an individual, not whether an individual intended to inflict injury or harm. When any nursing home employee or volunteer became aware of abuse, they were to report it immediately to the supervisor or officer of the day. That staff was to immediately ensure the proper notifications were made to the facility leadership and state agency per state and federal requirements. Seven components were in place to prevent abuse. All staff were responsible for preventing abuse and were educated on how to report abuse. Staff were to assess, plan care and services, and monitor residents with needs and behaviors. Risk factors for abuse included a history of cognitive	F 610		

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F 610	Continued From page 30 and sensory deficits, aggressive behaviors, behaviors such as entering other residents' rooms, wandering, and being socially inappropriate. Additional risk factors included communication disorders, nonverbal, and residents requiring heavy care or are totally dependent on staff. Appropriate interventions were to be identified and implemented for the resident involved and all other residents to prevent future occurrences. Residents were to be protected from the alleged offenders. Additional attention was to include consideration to provide safety for other residents as appropriate. If the resident could be at risk in the same environment, considerations to be made included changes in location. The facility failed to review the policy annually as required by federal regulation.	F 610		

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
April 5, 2021

Administrator
Mn Veterans Home - Luverne
1300 North Kniss, Po Box 539
Luverne, MN 56156

Re: Event ID: PT9511

Dear Administrator:

The above facility survey was completed on March 17, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

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2 000	Initial Comments	2 000		

*****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 3/17/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.

The following complaints were found to be

Minnesota Department of Health

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2 000	Continued From page 1 SUBSTANTIATED: H5631017C (MN67041), and H5631018C (MN7093), however NO licensing orders were issued. 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, the facility must acknowledge receipt of the electronic documents.	2 000		