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

July 31, 2020

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: June 11, 2020

Dear Administrator:

On June 30, 2020, we informed you that we may impose enforcement remedies.

On July 15, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On July 15, 2020, the situation of immediate jeopardy to potential health and safety cited at F389 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 15, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 15, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 15, 2020.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Norris Square is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 15, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794 Mobile: (320) 249-2805

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 11, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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,

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING ______ B. WING ______	C 07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

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F 000	INITIAL COMMENTS On 7/13/20 through 7/15/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5637005C The following complaint was found to be substantiated, however citations were issued due to actions taken by the facility prior to survey: H5637007C The following complaint was found to be unsubstantiated: H5637006C The survey resulted in an Immediate Jeopardy (IJ) at F689 the facility failed to assess R1's psychological needs, and implement immediate safety measures after R1 threatened to kill herself with a scissors. The IJ was removed on 7/15/20, at 11:38 a.m. but noncompliance remained at the lower scope and severity level of a D- isolated incident with no actual harm with potential for more than minimal harm. In addition, an extended survey was completed on (date), related to the substandard quality of care findings. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000	THIS PLAN AND RESPONSE TO THESE SURVEY FINDINGS IS WRITTEN SOLELY TO MAINTAIN CERTIFICATION IN THE MEDICARE PROGRAM. THESE WRITTEN RESPONSES DO NOT CONSTITUTE AN ADMISSION OF NONCOMPLIANCE WITH ANY REQUIREMENT NOR AN AGREEMENT WITH ANY FINDINGS. WE WISH TO PRESERVE OUR RIGHT TO DISPUTE THESE FINDINGS IN THEIR ENTIRETY AT ANY TIME AND IN ANY LEGAL ACTION. WE MAY SUBMIT A SEPARATE REQUEST FOR INFORMAL DISPUTE RESOLUTION FOR CERTAIN FINDINGS AND DETERMINATIONS.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Care Center Administrator

(X6) DATE: 8/7/2020

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**F 689** Resident R1 was hospitalized on 7/2/2020 after incident and chose not to return to facility. The facility initiated education on 7/7/20 and 7/14/20 for the lack of removal of items of harm from R1's room and notification procedure per policy for situations where self-harm or suicidal ideation are present. A facility audit of PHQ9 scores was completed on 7/13/20 to identify other residents that may be at risk for threats to self-harm. A comprehensive assessment will be completed on any resident that was found to be at risk and intervention implemented and care planned per policy. All residents are assessed for s/sx of depression via the PHQ9 assessment upon admission, quarterly and with a significant change in status. All residents are reviewed daily at IDT and any changes in the plan of care are determined.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a psychosocial assessment, implement safety measures, and notify appropriate parties for 1 of 1 residents (R1) who stated she wanted to kill herself with scissors she had in her possession, then cut her wrists with a butter knife and was transported to the hospital. The lack of facility assessment and implementation of safety measure, placed R1 in immediate jeopardy. The immediate jeopardy began on 7/1/20, at 5:00 p.m. when the facility failed to assess R1's psychological needs, and implement immediate safety measures after R1 threatened to kill herself with a scissors. The administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) on 7/14/20 at 4:00 p.m.	F 689		

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F 689	Continued From page 2 The IJ was removed on 7/15/20, at 11:38 a.m. but noncompliance remained at the lower scope and severity level of a D- isolated incident with no actual harm with potential for more than minimal harm. Findings include: R1's entry Minimum Data Set (MDS), dated 7/1/20, indicated an admission from the community on 7/1/20. R1's MDS, dated 7/2/20, included R1 had been discharged to a hospital on 7/2/20. R1's care plan dated 7/1/20, included, "I have an alteration in mood or behavioral expression." R1's goal was, "I will demonstrate effective coping skills through the review date." R1's interventions directed staff, "Encourage me to participate in activities of interest. Explain all procedures to me. Intervene as necessary to protect the rights of others. Approach/Speak in a calm manner. Divert attention. Remove me from the situation and take me to an alternate location as needed." The care plan listed diagnoses of anxiety disorder and macular degeneration with vision loss in both eyes. R1's body audit, dated 7/1/20, indicated R1 did not have any scratches, cuts or skin tears. R1's Brief Interview for Mental Status, Delirium and Communication assessment, dated 7/2/20, indicated R1 had moderately impaired cognition. R1's incident report dated 7/2/20, at 2:30 p.m. included, Resident Services Director entered residents room around 2:30 pm to do initial assessment. "Resident admitted to this facility on 7/1/2020 at 10:00 AM. Resident was sitting in her chair listening to her radio with her lunch in front of her, untouched. Resident Services Director	F 689	Ongoing audits are being completed on the residents who trigger for a threat to self harm on the PHQ-9 and for those that exhibit statements or actions that may indicate a threat to self harm weekly for 6 weeks and the results will be reported to the QA Committee to ensure ongoing compliance. Upon hire, all staff will receive education on the Threats to Self-Harm and Prevention Policy and Guidelines as part of their orientation and be completed before working directly with residents. Audits have been completed to verify understand of the policy and expectations on the Threats to Self-Harm policy and continues to be ongoing Random audits will continue for the next 4 weeks and the results will be reported to the QA committee to ensure ongoing compliance. Date of compliance is 8/9/2020.	

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F 689	Continued From page 3 noticed resident was holding a butter knife from lunch. Writer kept an eye on it, and as writer started talking with resident, res [resident] turned over her right wrist and started cutting herself with the knife. There was already a red mark on her wrist and started cutting herself with the knife. Writer asked what she was doing, and resident started to cry. Writer asked if she could have the knife and resident handed it over right away. Resident then stated, 'I just want to die.' Resident service director stayed with resident and texted nursing staff for assistance. Resident Service Director informed by nursing to stay with resident on 1:1 [one on one] until a safe plan could be made. Resident assessed and had superficial abrasions to right wrist. NP [nurse practitioner], Family updated and 911 called. Resident transferred to United Hospital via EMT [emergency medical transport]. Information provided to this facility prior to resident being admitted there was no indication of prior attempts of resident trying to harm self. After resident admitted to this facility she did not voice any concerns with self harm and there were no indications that resident would self harm. Internal investigation started and all parties notified." R1's progress note dated 7/2/20, at 1 :07 a.m. indicated R1 was agitated and restless early in the shift and wanted to go to the bathroom right away. The progress note further indicated R1 pretended to take her medications, but would hide medication in her pocket and was educated about the risk of not taking medications. However, the note failed to include any attempt to find out why R1 did not want to take the medication or source of her agitation. R1's progress note dated 7/2/20, at 8:09 a.m.	F 689		

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F 689	Continued From page 4	F 689		

included, "Yelling out taking off her oxygen. Writer approached resident to see how she could be helped. Resident had her phone, her call light her oxygen and her radio all in her left hand with lines twisted. Resident had walking cane in right hand. As writer approached resident swung cane in direction of writer. Writer grabbed cane to stop cane from hitting writer. Resident stated that she didn't mean to hit writer and began to calm down. Writer untangled all the cords and organized room, placed 02 [oxygen] back on resident. Offered PRN [as needed] lorazapem for anxiety but resident refused. Attempted to give AM medications but resident stated that it was too early for that. Was then making statements like, 'Why are you guys so nice to me?' but then would say 'I know you're going to kill me.' Then asked writer to call family member [F-A]. Writer called [F-A] and left resident alone, letting her know that writer would be back after breakfast for her morning medications." The note failed to include an assessment of R1's distress.

R1's progress note dated 7/2/20, at 10:34 a.m. included, "Continues to make statements thinking the staff are going to kill her. Reassured resident that staff was not going to kill her and that she was safe." The progress note failed to include any assessment of R1's distress.

R1's progress note dated 7/2/20, at 2:42 p.m. included, "Nurse manager states that resident is going to the hospital because she was seen trying to cut herself with a knife." "No puncture noted to wrist. All sharp objects collected from room and placed in nurse managers office."

R1's progress note written by social services director (SSD) on 7/2/20, 4:14 p.m. included,

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F 689	Continued From page 5 "Writer entered room around 2:30 pm to do initial assessments. Resident was sitting in her chair listening to her radio with her lunch in front of her, untouched. Writer noticed resident was holding her knife from lunch. Writer kept an eye on it, and as writer started talking with resident, res [resident] turned over her right wrist and started cutting herself with the knife. There was already a red mark on her wrist, making it appear that she had been doing this prior to writer entering her room. Writer asked what she was doing, and resident started to cry. Writer asked If she could have the knife and resident handed it over right away. Resident then stated: 'I just want to die. My [family member] says that I lie. That I just sit here and make things up, but I don't. I don't do that. I'm blind. I can't do anything. I'm better off dead. [family member] blames me for everything.' Writer told resident that she was here to listen. Resident talked about how her [family member] has a lot on [family member's] plate as [family member] is responsible for a [another family member] as well. Resident stated, 'my [family member] takes everything out on me.' She stated that she broke her phone after the phone call with her [family member] earlier this afternoon. She said, 'I shouldn't have done that. Now I don't have a phone.' and was very tearful. Writer reassured resident that staff can get her a new phone. Resident also told writer that she is scared because she can't see, and she has anxiety. Resident stated she does not have a plan in place to kill herself, and that this is the first time she has done something like this. She asked writer not to say anything to anyone about her wrist. Writer explained that she has to tell the nursing staff so they can help her and that she will be going to the hospital, as 911 was already called. Writer sat with resident talking with her	F 689		

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F 689	Continued From page 6	F 689		

until ambulance arrived to take her to the hospital. She had significant changes in behavior during that time, from happy and talking about her [family member] and how she enjoyed sewing, to very tearful and upset talking about the conversation she had with her [family member] this afternoon. Resident was transported to United Hospital per [family member's] recommendation."

R1's progress note, dated 7/7/20, at 3:58 p.m. included, "On Wednesday July 1st at around 5:00 pm, I have got report that, the patient hid the Caesar [sic] in her shoe. Patient said "I want to kill myself." I gave sometime to patient and asked if I can help her, patient asked me if I can call her [family member, F-A], I promised her to call her [F-A] and J [sic] asked her to give me the caesar [sic] and she gave to me. I put the Caesar [sic] away from patient and called her [F-A]. after pt [patient] talked to her [F-A], pt was happy and not showed such behavior. Nurse told aid to watch the pt and report if any behavior repeated."

R1's Investigation Summary, dated 7/8/20, included, R1 had a previous incident on 7/1/20, at 5:00 p.m., "Resident had two pairs of scissors. Resident Assistant [RA] asked resident what she was doing with the scissors and resident stated she was going to kill herself with them." The RA notified a nurse and R1 repeated to the nurse she was going to kill herself. The nurse listened to R1 and R1 did hand the scissors to the nurse. The nurse placed the scissors in the resident's drawer which was still accessible to R1."After resident left facility in anticipation of residents return, a room sweep was performed to identify any objects that resident could self-harm with and they were removed including the scissors." "The

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F 689	Continued From page 7 nurse on duty that found the scissors received written corrective action to be placed in personnel file and re-educated on Threats to Harm Self and Prevention Policy and expectations to follow the policy. All other staff to be re-educated on Threats to Harm Self and Prevention Policy." When interviewed on 7/13/20, at 1:30 p.m. licensed practical nurse (LPN)-A stated she had not heard about any incident with R1 and had not received any recent training on residents at risk for self-harm. She had worked with R1 on 7/1/20 and noted agitated behaviors. When interviewed on 7/13/20, at 1:45 p.m. NA-E stated he worked with R1 on the morning of 7/2/20. NA-E heard R1 screaming and yelling at 6:00 a.m. NA-E attempted to assist R1, but she struck him with her cane. NA-E reported R1's agitation to RN-H. When interviewed on 7/13/20, at 1:55 p.m. RN-D stated when he had arrived at work on 7/2/20, he found a pair of scissors on R1's dresser, but was not aware that R1 had threatened to harm herself with those scissors and did not remove them. R1 was then left alone in the room without being monitored. RN-H later removed the scissors from the dresser, but RN-D did not know what time this was. When interviewed on 7/13/20, at 3:13 p.m. the SSD had found R1 with the butter knife on 7/2/20, and stayed with R1 while awaiting transport to the hospital. SSD had not had any prior training at the facility on how to respond to residents with threats of self-harm, but had notified nursing and stayed with R1 as described in the incident report. The SSD stated she completed a Threats to Self	F 689		

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	245637	A. BUILDING ______ B. WING ______	C 07/15/2020

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F 689	Continued From page 8	F 689		

Harm Assessment on 7/2/20, while waiting for the ambulance.

R1's Threats to Self Harm Assessment dated 7/2/20, included, "Resident was using her knife from lunch to cut her right wrist during visit with writer this afternoon. Resident stated she just wanted to die and was very upset after a phone conversation with her daughter. Resident is on medication for anxiety and depression. She stated that she is scared because she cannot see and is in a new environment She also told writer she has never done anything like this to herself before. Writer stayed with resident until the ambulance arrived to transport her to the hospital."

When interviewed on 7/13/20, at 3:29 p.m. nursing assistant (NA)-D stated he had worked with R1 on 7/1/20, and had answered her call light around 5:00 p.m. R1 had a scissors in her hand and reported she had another scissors up her sleeve. NA-D asked R1 for the scissors and R1 refused to give them to him. R1 stated she was going to kill herself with the scissors. NA-D reported this immediately to RN-I. R1 gave the scissors to RN-I.

When interviewed on 7/13/20, at 4:08 p.m. RN-I stated on 7/1/20, around 5:00 p.m. NA-D notified her R1 had a pair of scissors and stated she was going to kill herself with them. RN-I was able to get the scissors from R1 and placed them on top of R1's dresser in her room. RN-I stated she did a body assessment to ensure R1 did not injure herself. RN-I left the room and when she returned R1 was on the phone with a family member. RN-I did not complete a comprehensive assessment of R1's suicide risk,

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F 689	Continued From page 9 did not notify the physician or family member and did not report this incident to a manager, director of nursing, or social services. RN-I also did not place any interventions to ensure R1 did not harm self, such as removing any sharp objects or cords, (including the scissors) from R1's access or place any other interventions to protect R1. RN-I had not documented the incident that occurred on 7/1/20, until directed to on 7/7/20. When interviewed on 7/13/20, at 4:24 p.m. family member (FM)-A stated, R1 was upset when they spoke on 7/1/20, and R1 stated, 'You don't know what they are trying to do - you don't know you don't know they are trying to hurt me.' FM-A indicated they had not been made aware R1 had scissors in her room, and the facility only called FM-A to tell them when R1 was on the way to the hospital. FM-A stated the facility told them R1 had a butter knife and tried to kill herself. FM-A stated if the facility had called and told them R1 had scissors and threatened to kill herself the day before, family would have come to calm her down and see what they could do to get her help and prevent self-harm. However, this information had never been relayed to them until R1 was on the way to the hospital after the second incident. When interviewed on 7/13/20, at 2:55 p.m. RN-A stated they had not worked with R1. RN-A had training via Relias, which is an online training, about challenging behaviors and communication with people with dementia when hired. However, no specific training on self-harm or suicidal ideation's in the past couple weeks. When interviewed on 7/13/20, at 3:13 p.m. NA-A stated they had not received any training in the past couple weeks on self-harm or suicidal	F 689		

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ideation's.

When interviewed on 7/13/20, at 3:34 p.m. NA-B indicated she did not have training on working with residents with self-harm concerns or suicidal ideation.

When interviewed on 7/14/20, at 11:28 a.m. RN-H stated the morning of 7/2/20, R1 was yelling and hitting the walls with her cane and attempted to hit staff also. RN-H stated she asked R1 to stop doing that. She found scissors on top of R1's dresser and removed those and some pushpins from the cork board. RN-H stated she let the director of nursing (DON) know she had removed sharp objects from R1's room. She had removed them due to fear of R1 hurting staff with them, and was not aware at that time that R1 had threatened to kill herself with those scissors.

On 7/14/20, at 11:44 a.m. housekeeper (H)-A reported she had not recently reviewed what to do if a resident threatened self harm. H-A reported she would probably tell the resident not to do it, take the object away from the resident and push the call light for a nurse. H-A reported there was not a system in which resident safety precautions were communicated to her. H-A stated she thought the nursing assistant might tell her if there were precautions.

When interviewed on 7/14/20, at 12:11 p.m. NA-F stated she had just received some training today on how to manage self-harm behaviors, by reading some information and signing a form.

When interviewed on 7/14/20, at 1:27 a.m. the DON stated, RN-H had reported on 7/2/20 that R1 was striking out at staff with her cane and had

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F 689	Continued From page 11 removed some sharp objects from her room. The DON had not been aware of the 7/1/20 incident with the scissors until after starting to investigate the 7/2/20, incident with the butter knife. The DON stated for the 7/1/20, incident RN-I should have assessed R1 for self harm, remove the two pairs of scissors, not leave alone, and notify the practitioner, all which were not done. RN-I had received disciplinary notice and training. When interviewed on 7/14/20, at 11:45 a.m. dietary aide (DA)-C stated they had worked the day R1 was sent to the hospital. DA-C was not aware of any concern about R1 having any sharp utensils. This was not relayed to dietary staff. If DA-C had been aware, they would have provided plastic utensils rather than a regular butter knife and would have known to cut up food for R1. DA-C stated if a resident should not have sharp objects such as knives or glassware, it should be noted on their dietary card. DA-C had never received any training from the facility on what to do if someone threatened suicide or self-harm. When interviewed on 7/14/20, at 11:20 a.m. DA-B stated that last week they were given a sheet to read on signs to watch for if someone was at risk of harming themselves, but had not received any training. They had to sign that they read the sheet. DA-B stated she doesn't know how dietary would be informed if someone wanted to harm themselves and wanted to ask, but didn't know who to ask follow up questions to. When interviewed on 7/14/20, at 11:22 a.m. DA-A indicated she did not have training on working with residents with self-harm concerns or suicidal ideation, but last week they had to read and sign sheet on what signs to watch for. DA-A	F 689		

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F 689	Continued From page 12 indicated supervisory staff should let them know if a resident has any precautions related to self-harm or special dinging service needs. DA-A also stated she didn't think dietary staff could know about suicidal tendencies in a resident because that was a, "HIPPA [Health Insurance Portability and Accountability Act] thing." DA-A indicated dietary staff were told not to enter R1's room because R1 had hit an aide with her cane. Dietary staff were not given any instruction to withhold items such as knives or sharp objects from R1's meal tray. When interviewed on 7/14/20, at 11:45 a.m. the director of dietary services (DDS) indicated there should be dining precautions in place for residents identified with risk for self-harm including only giving them plastics, and not giving glass or something that would break. The DDS also indicated that they would also give a lighter weight plastic silverware, and a plastic knife only if needed. The DDS indicated they did not know what happened in R1's case, and they would have to check with staff to verify the communication break down. DDS stated if we had known the issue, they would have only provided disposable plastic. When interviewed on 7/14/20, at 11:50 a.m. RN-G stated that when R1 was threatening to kill herself on 7/1/20, RN-I should have followed their procedure which was to notify the clinical coordinator and director of nursing (DON), call 911, and not leave the resident alone. Staff should have removed all objects residents could use to harm themselves and make sure the resident was safe. Dietary should have notified not to provide any objects that could be used to harm oneself if at risk. R1 should have been	F 689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 13	F 689		

assessed for self-harm and immediate interventions should have been placed. RN-G stated since the facility is so new and self-harm or suicidal ideation's had never come up before, they had not done any specific training on this for staff. However, there was a Relias annual training on vulnerable adult requirements, observing and reporting.

When interviewed on 7/14/20, at 12:28 p.m. NA-C indicated she did not receive on-site training on working with residents with self-harm concerns or suicidal ideation and stated, "We do an annual Relias training but I did not receive any education here. I would definitely try to find a supervisor or a nurse, talk to the resident to determine what to do best, especially if felt the person was going to actively do it in the minutes that I was there, would not leave the person alone, would look for sharp objects, remove call clip or any kind of cord or anything they could harm themselves, get it totally out of the room."

When interviewed on 7/14/20, at 12:35 p.m. RN-C indicated she did not receive training on working with residents with self-harm concerns or suicidal ideation in the last couple weeks.
A facility education entitled Guidelines for Handling Suicide Threats Policy and Threats to Harm Self and Prevention Policy had a document to sign indicating staff had received training on this. Staff who had worked since the 7/2/20, incident with R1, but had as of 7/14/20, at 12:49 p.m. yet to receive the training included: RN-A, RN-B, RN-C, RN-E, RN-F, NA-A, NA-B, NA-C, NA-D, NA-F, PT-A, DA-C. This was verified by the administrator.

The facilities Guidelines for Handling Suicide

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F 689	Continued From page 14 Threats Policy, reviewed 2/16, indicated: 1. All suicide threats will be taken seriously and evaluated based on what is known and observed/assessed regarding the resident/client and what the physician recommends. 2. If a resident/client threatens suicide, designate a staff person to stay with him or her while the nurse is notified. 3. The nurse will notify the social worker or designee to assist in assessment and include a psychologist or psychiatrist as available. 4. The nurse will notify the family and physician promptly a recommendation for psych services will be reviewed with the physician and family for consideration of either inpatient geri-psych services or in-house referral. 5. Remove as many potentially lethal instruments from the room as possible, including medications, razors, tableware, nail files, glass, neckties, and panty hose. 6. Obtain direction from physician regarding psychiatric consultation, transfer to hospital, medication. Note that if suicidal threats are made, medication alterations may take an extended amount of time to reach full effectiveness. Therefore, if an identified plan threat is known admission to an inpatient setting should be strongly considered. 7. If satisfying direction has not been received for the physician and/or if any subsequent unmanageable suicide threats are made, and/or if you feel that the resident/client's mental condition renders him/her dangerous to self, call 911. 8. Take time to talk to the resident/client. See questions to ask a potentially suicidal resident/client. 9. Assure that sufficient observation and assessment is scheduled around the clock to reduce the chance of self injury. See guidelines	F 689		

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F 689	Continued From page 15 for assessing suicide risk to determine frequency of monitoring. 10. If after repetitive suicidal ideation's or the need for 1:1 supervision, it becomes evident that the facility cannot provide adequate supervision and safety of the resident or others, the interdisciplinary team in partnership with the physician and psych services should consider alternate placement. 11. In the event that the resident is determined to need continuous observation until a longer term plan is implemented or emergency personnel are summoned, 1:1 supervision or indirect supervision through video observation may be used as indicated and compliant with appropriate consents and HIPPA requirements. The immediate jeopardy that began on 7/1/20, was removed on 7/15/20, when the facility reviewed their policies/procedures and ensured all staff would be trained in how to manage residents who may be at risk of harming themselves, prior to beginning their next shift. However, the noncompliance remained at the lower scope and severity level of a D- isolated incident with no actual harm with potential for more than minimal harm.	F 689		

Electronically delivered
July 31, 2020

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

Re: State Nursing Home Licensing Orders
Event ID: PZRP11

Dear Administrator:

The above facility was surveyed on July 13, 2020 through July 15, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794 Mobile: (320) 249-2805

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900

St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/13/20, through 7/15/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to NOT be in compliance with the MN State Licensure. The following complaint found to be	2 000	Corrected.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Care Center Administrator

(X6) DATE 8/7/2020

Minnesota Department of Health

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2 000	Continued From page 1 SUBSTANTIATED: H5637005C, licensing orders were issued. The following complaint was found to be SUBSTANTIATED: H5637007C, no licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5637006C 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. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by:	2 830		

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Continued From page 3

Based on interview and document review, the facility failed to complete a psychosocial assessment, implement safety measures, and notify appropriate parties for 1 of 1 residents (R1) who stated she wanted to kill herself with scissors she had in her possession, then cut her wrists with a butter knife and was transported to the hospital. The lack of facility assessment and implementation of safety measure, placed R1 in immediate jeopardy.

The immediate jeopardy began on 7/1/20, at 5:00 p.m. when the facility failed to assess R1's psychological needs, and implement immediate safety measures after R1 threatened to kill herself with a scissors. The administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) on 7/14/20 at 4:00 p.m. The IJ was removed on 7/15/20, at 11:38 a.m. but noncompliance remained at the lower scope and severity level of a D- isolated incident with no actual harm with potential for more than minimal harm.

Findings include:

R1's entry Minimum Data Set (MDS), dated 7/1/20, indicated an admission from the community on 7/1/20. R1's MDS, dated 7/2/20, included R1 had been discharged to a hospital on 7/2/20.

R1's care plan dated 7/1/20, included, "I have an alteration in mood or behavioral expression." R1's goal was, "I will demonstrate effective coping skills through the review date." R1's interventions directed staff, "Encourage me to participate in activities of interest. Explain all procedures to me. Intervene as necessary to protect the rights of others. Approach/Speak in a calm manner. Divert

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attention. Remove me from the situation and take me to an alternate location as needed." The care plan listed diagnoses of anxiety disorder and macular degeneration with vision loss in both eyes. R1's body audit, dated 7/1/20, indicated R1 did not have any scratches, cuts or skin tears. R1's Brief Interview for Mental Status, Delirium and Communication assessment, dated 7/2/20, indicated R1 had moderately impaired cognition.

R1's incident report dated 7/2/20, at 2:30 p.m. included, Resident Services Director entered residents room around 2:30 pm to do initial assessment. "Resident admitted to this facility on 7/1/2020 at 10:00 AM. Resident was sitting in her chair listening to her radio with her lunch in front of her, untouched. Resident Services Director noticed resident was holding a butter knife from lunch. Writer kept an eye on it, and as writer started talking with resident, res [resident] turned over her right wrist and started cutting herself with the knife. There was already a red mark on her wrist and started cutting herself with the knife. Writer asked what she was doing, and resident started to cry. Writer asked if she could have the knife and resident handed it over right away. Resident then stated, 'I just want to die.' Resident service director stayed with resident and texted nursing staff for assistance. Resident Service Director informed by nursing to stay with resident on 1:1 [one on one] until a safe plan could be made. Resident assessed and had superficial abrasions to right wrist. NP [nurse practitioner], Family updated and 911 called. Resident transferred to United Hospital via EMT [emergency medical transport]. Information provided to this facility prior to resident being admitted there was no indication of prior attempts of resident trying to harm self. After resident admitted to this facility she did not voice any

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2 830	Continued From page 5 concerns with self harm and there were no indications that resident would self harm. Internal investigation started and all parties notified." R1's progress note dated 7/2/20, at 1 :07 a.m. indicated R1 was agitated and restless early in the shift and wanted to go to the bathroom right away. The progress note further indicated R1 pretended to take her medications, but would hide medication in her pocket and was educated about the risk of not taking medications. However, the note failed to include any attempt to find out why R1 did not want to take the medication or source of her agitation. R1's progress note dated 7/2/20, at 8:09 a.m. included, "Yelling out taking off her oxygen. Writer approached resident to see how she could be helped. Resident had her phone, her call light her oxygen and her radio all in her left hand with lines twisted. Resident had walking cane in right hand. As writer approached resident swung cane in direction of writer. Writer grabbed cane to stop cane from hitting writer. Resident stated that she didn't mean to hit writer and began to calm down. Writer untangled all the cords and organized room, placed 02 [oxygen] back on resident. Offered PRN [as needed] lorazapem for anxiety but resident refused. Attempted to give AM medications but resident stated that it was too early for that. Was then making statements like, 'Why are you guys so nice to me?' but then would say 'I know you're going to kill me.' Then asked writer to call family member [F-A]. Writer called [F-A] and left resident alone, letting her know that writer would be back after breakfast for her morning medications." The note failed to include an assessment of R1's distress. R1's progress note dated 7/2/20, at 10:34 a.m.	2 830		

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2 830	Continued From page 6 included, "Continues to make statements thinking the staff are going to kill her. Reassured resident that staff was not going to kill her and that she was safe." The progress note failed to include any assessment of R1's distress. R1's progress note dated 7/2/20, at 2:42 p.m. included, "Nurse manager states that resident is going to the hospital because she was seen trying to cut herself with a knife." "No puncture noted to wrist. All sharp objects collected from room and placed in nurse managers office." R1's progress note written by social services director (SSD) on 7/2/20, 4:14 p.m. included, "Writer entered room around 2:30 pm to do initial assessments. Resident was sitting in her chair listening to her radio with her lunch in front of her, untouched. Writer noticed resident was holding her knife from lunch. Writer kept an eye on it, and as writer started talking with resident, res [resident] turned over her right wrist and started cutting herself with the knife. There was already a red mark on her wrist, making it appear that she had been doing this prior to writer entering her room. Writer asked what she was doing, and resident started to cry. Writer asked If she could have the knife and resident handed it over right away. Resident then stated: 'I just want to die. My [family member] says that I lie. That I just sit here and make things up, but I don't. I don't do that. I'm blind. I can't do anything. I'm better off dead. [family member] blames me for everything.' Writer told resident that she was here to listen. Resident talked about how her [family member] has a lot on [family member's] plate as [family member] is responsible for a [another family member] as well. Resident stated, 'my [family member] takes everything out on me.' She stated that she broke her phone after the phone call with	2 830		

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her [family member] earlier this afternoon. She said, 'I shouldn't have done that. Now I don't have a phone.' and was very tearful. Writer reassured resident that staff can get her a new phone. Resident also told writer that she is scared because she can't see, and she has anxiety. Resident stated she does not have a plan in place to kill herself, and that this is the first time she has done something like this. She asked writer not to say anything to anyone about her wrist. Writer explained that she has to tell the nursing staff so they can help her and that she will be going to the hospital, as 911 was already called. Writer sat with resident talking with her until ambulance arrived to take her to the hospital. She had significant changes in behavior during that time, from happy and talking about her [family member] and how she enjoyed sewing, to very tearful and upset talking about the conversation she had with her [family member] this afternoon. Resident was transported to United Hospital per [family member's] recommendation."

R1's progress note, dated 7/7/20, at 3:58 p.m. included, "On Wednesday July 1st at around 5:00 pm, I have got report that, the patient hid the Caesar [sic] in her shoe. Patient said "I want to kill myself." I gave sometime to patient and asked if I can help her, patient asked me if I can call her [family member, F-A], I promised her to call her [F-A] and J [sic] asked her to give me the caesar [sic] and she gave to me. I put the Caesar [sic] away from patient and called her [F-A]. after pt [patient] talked to her [F-A], pt was happy and not showed such behavior. Nurse told aid to watch the pt and report if any behavior repeated."

R1's Investigation Summary, dated 7/8/20, included, R1 had a previous incident on 7/1/20, at

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2 830	Continued From page 8 5:00 p.m., "Resident had two pairs of scissors. Resident Assistant [RA] asked resident what she was doing with the scissors and resident stated she was going to kill herself with them." The RA notified a nurse and R1 repeated to the nurse she was going to kill herself. The nurse listened to R1 and R1 did hand the scissors to the nurse. The nurse placed the scissors in the resident's drawer which was still accessible to R1."After resident left facility in anticipation of residents return, a room sweep was performed to identify any objects that resident could self-harm with and they were removed including the scissors." "The nurse on duty that found the scissors received written corrective action to be placed in personnel file and re-educated on Threats to Harm Self and Prevention Policy and expectations to follow the policy. All other staff to be re-educated on Threats to Harm Self and Prevention Policy." When interviewed on 7/13/20, at 1:30 p.m. licensed practical nurse (LPN)-A stated she had not heard about any incident with R1 and had not received any recent training on residents at risk for self-harm. She had worked with R1 on 7/1/20 and noted agitated behaviors. When interviewed on 7/13/20, at 1:45 p.m. NA-E stated he worked with R1 on the morning of 7/2/20. NA-E heard R1 screaming and yelling at 6:00 a.m. NA-E attempted to assist R1, but she struck him with her cane. NA-E reported R1's agitation to RN-H. When interviewed on 7/13/20, at 1:55 p.m. RN-D stated when he had arrived at work on 7/2/20, he found a pair of scissors on R1's dresser, but was not aware that R1 had threatened to harm herself with those scissors and did not remove them. R1 was then left alone in the room without being	2 830		

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2 830	Continued From page 9 monitored. RN-H later removed the scissors from the dresser, but RN-D did not know what time this was. When interviewed on 7/13/20, at 3:13 p.m. the SSD had found R1 with the butter knife on 7/2/20, and stayed with R1 while awaiting transport to the hospital. SSD had not had any prior training at the facility on how to respond to residents with threats of self-harm, but had notified nursing and stayed with R1 as described in the incident report. The SSD stated she completed a Threats to Self Harm Assessment on 7/2/20, while waiting for the ambulance. R1's Threats to Self Harm Assessment dated 7/2/20, included, "Resident was using her knife from lunch to cut her right wrist during visit with writer this afternoon. Resident stated she just wanted to die and was very upset after a phone conversation with her daughter. Resident is on medication for anxiety and depression. She stated that she is scared because she cannot see and is in a new environment She also told writer she has never done anything like this to herself before. Writer stayed with resident until the ambulance arrived to transport her to the hospital." When interviewed on 7/13/20, at 3:29 p.m. nursing assistant (NA)-D stated he had worked with R1 on 7/1/20, and had answered her call light around 5:00 p.m. R1 had a scissors in her hand and reported she had another scissors up her sleeve. NA-D asked R1 for the scissors and R1 refused to give them to him. R1 stated she was going to kill herself with the scissors. NA-D reported this immediately to RN-I. R1 gave the scissors to RN-I.	2 830		

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When interviewed on 7/13/20, at 4:08 p.m. RN-I stated on 7/1/20, around 5:00 p.m. NA-D notified her R1 had a pair of scissors and stated she was going to kill herself with them. RN-I was able to get the scissors from R1 and placed them on top of R1's dresser in her room. RN-I stated she did a body assessment to ensure R1 did not injure herself. RN-I left the room and when she returned R1 was on the phone with a family member. RN-I did not complete a comprehensive assessment of R1's suicide risk, did not notify the physician or family member and did not report this incident to a manager, director of nursing, or social services. RN-I also did not place any interventions to ensure R1 did not harm self, such as removing any sharp objects or cords, (including the scissors) from R1's access or place any other interventions to protect R1. RN-I had not documented the incident that occurred on 7/1/20, until directed to on 7/7/20.

When interviewed on 7/13/20, at 4:24 p.m. family member (FM)-A stated, R1 was upset when they spoke on 7/1/20, and R1 stated, 'You don't know what they are trying to do - you don't know you don't know they are trying to hurt me.' FM-A indicated they had not been made aware R1 had scissors in her room, and the facility only called FM-A to tell them when R1 was on the way to the hospital. FM-A stated the facility told them R1 had a butter knife and tried to kill herself. FM-A stated if the facility had called and told them R1 had scissors and threatened to kill herself the day before, family would have come to calm her down and see what they could do to get her help and prevent self-harm. However, this information had never been relayed to them until R1 was on the way to the hospital after the second incident.

When interviewed on 7/13/20, at 2:55 p.m. RN-A

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2 830	Continued From page 11 stated they had not worked with R1. RN-A had training via Relias, which is an online training, about challenging behaviors and communication with people with dementia when hired. However, no specific training on self-harm or suicidal ideation's in the past couple weeks. When interviewed on 7/13/20, at 3:13 p.m. NA-A stated they had not received any training in the past couple weeks on self-harm or suicidal ideation's. When interviewed on 7/13/20, at 3:34 p.m. NA-B indicated she did not have training on working with residents with self-harm concerns or suicidal ideation. When interviewed on 7/14/20, at 11:28 a.m. RN-H stated the morning of 7/2/20, R1 was yelling and hitting the walls with her cane and attempted to hit staff also. RN-H stated she asked R1 to stop doing that. She found scissors on top of R1's dresser and removed those and some pushpins from the cork board. RN-H stated she let the director of nursing (DON) know she had removed sharp objects from R1's room. She had removed them due to fear of R1 hurting staff with them, and was not aware at that time that R1 had threatened to kill herself with those scissors. On 7/14/20, at 11:44 a.m. housekeeper (H)-A reported she had not recently reviewed what to do if a resident threatened self harm. H-A reported she would probably tell the resident not to do it, take the object away from the resident and push the call light for a nurse. H-A reported there was not a system in which resident safety precautions were communicated to her. H-A stated she thought the nursing assistant might tell her if there were precautions.	2 830		

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2 830	Continued From page 12 When interviewed on 7/14/20, at 12:11 p.m. NA-F stated she had just received some training today on how to manage self-harm behaviors, by reading some information and signing a form. When interviewed on 7/14/20, at 1:27 a.m. the DON stated, RN-H had reported on 7/2/20 that R1 was striking out at staff with her cane and had removed some sharp objects from her room. The DON had not been aware of the 7/1/20 incident with the scissors until after starting to investigate the 7/2/20, incident with the butter knife. The DON stated for the 7/1/20, incident RN-I should have assessed R1 for self harm, remove the two pairs of scissors, not leave alone, and notify the practitioner, all which were not done. RN-I had received disciplinary notice and training. When interviewed on 7/14/20, at 11:45 a.m. dietary aide (DA)-C stated they had worked the day R1 was sent to the hospital. DA-C was not aware of any concern about R1 having any sharp utensils. This was not relayed to dietary staff. If DA-C had been aware, they would have provided plastic utensils rather than a regular butter knife and would have known to cut up food for R1. DA-C stated if a resident should not have sharp objects such as knives or glassware, it should be noted on their dietary card. DA-C had never received any training from the facility on what to do if someone threatened suicide or self-harm. When interviewed on 7/14/20, at 11:20 a.m. DA-B stated that last week they were given a sheet to read on signs to watch for if someone was at risk of harming themselves, but had not received any training. They had to sign that they read the sheet. DA-B stated she doesn't know how dietary would be informed if someone	2 830		

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wanted to harm themselves and wanted to ask, but didn't know who to ask follow up questions to.

When interviewed on 7/14/20, at 11:22 a.m. DA-A indicated she did not have training on working with residents with self-harm concerns or suicidal ideation, but last week they had to read and sign sheet on what signs to watch for. DA-A indicated supervisory staff should let them know if a resident has any precautions related to self-harm or special dinging service needs. DA-A also stated she didn't think dietary staff could know about suicidal tendencies in a resident because that was a, "HIPPA [Health Insurance Portability and Accountability Act] thing." DA-A indicated dietary staff were told not to enter R1's room because R1 had hit an aide with her cane. Dietary staff were not given any instruction to withhold items such as knives or sharp objects from R1's meal tray.

When interviewed on 7/14/20, at 11:45 a.m. the director of dietary services (DDS) indicated there should be dining precautions in place for residents identified with risk for self-harm including only giving them plastics, and not giving glass or something that would break. The DDS also indicated that they would also give a lighter weight plastic silverware, and a plastic knife only if needed. The DDS indicated they did not know what happened in R1's case, and they would have to check with staff to verify the communication break down. DDS stated if we had known the issue, they would have only provided disposable plastic.

When interviewed on 7/14/20, at 11:50 a.m. RN-G stated that when R1 was threatening to kill herself on 7/1/20, RN-I should have followed their procedure which was to notify the clinical

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14	2 830		

coordinator and director of nursing (DON), call 911, and not leave the resident alone. Staff should have removed all objects residents could use to harm themselves and make sure the resident was safe. Dietary should have notified not to provide any objects that could be used to harm oneself if at risk. R1 should have been assessed for self-harm and immediate interventions should have been placed. RN-G stated since the facility is so new and self-harm or suicidal ideation's had never come up before, they had not done any specific training on this for staff. However, there was a Relias annual training on vulnerable adult requirements, observing and reporting.

When interviewed on 7/14/20, at 12:28 p.m. NA-C indicated she did not receive on-site training on working with residents with self-harm concerns or suicidal ideation and stated, "We do an annual Relias training but I did not receive any education here. I would definitely try to find a supervisor or a nurse, talk to the resident to determine what to do best, especially if felt the person was going to actively do it in the minutes that I was there, would not leave the person alone, would look for sharp objects, remove call clip or any kind of cord or anything they could harm themselves, get it totally out of the room."

When interviewed on 7/14/20, at 12:35 p.m. RN-C indicated she did not receive training on working with residents with self-harm concerns or suicidal ideation in the last couple weeks.

A facility education entitled Guidelines for Handling Suicide Threats Policy and Threats to Harm Self and Prevention Policy had a document to sign indicating staff had received training on this. Staff who had worked since the 7/2/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33301	A. BUILDING: ____ B. WING ____	C 07/15/2020

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2 830	Continued From page 15 incident with R1, but had as of 7/14/20, at 12:49 p.m. yet to receive the training included: RN-A, RN-B, RN-C, RN-E, RN-F, NA-A, NA-B, NA-C, NA-D, NA-F, PT-A, DA-C. This was verified by the administrator. The facilities Guidelines for Handling Suicide Threats Policy, reviewed 2/16, indicated: 1. All suicide threats will be taken seriously and evaluated based on what is known and observed/assessed regarding the resident/client and what the physician recommends. 2. If a resident/client threatens suicide, designate a staff person to stay with him or her while the nurse is notified. 3. The nurse will notify the social worker or designee to assist in assessment and include a psychologist or psychiatrist as available. 4. The nurse will notify the family and physician promptly a recommendation for psych services will be reviewed with the physician and family for consideration of either inpatient geri-psych services or in-house referral. 5. Remove as many potentially lethal instruments from the room as possible, including medications, razors, tableware, nail files, glass, neckties, and panty hose. 6. Obtain direction from physician regarding psychiatric consultation, transfer to hospital, medication. Note that if suicidal threats are made, medication alterations may take an extended amount of time to reach full effectiveness. Therefore, if an identified plan threat is known admission to an inpatient setting should be strongly considered. 7. If satisfying direction has not been received for the physician and/or if any subsequent unmanageable suicide threats are made, and/or if you feel that the resident/client's mental condition renders him/her dangerous to self, call 911.	2 830		

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2 830	Continued From page 16 8. Take time to talk to the resident/client. See questions to ask a potentially suicidal resident/client. 9. Assure that sufficient observation and assessment is scheduled around the clock to reduce the chance of self injury. See guidelines for assessing suicide risk to determine frequency of monitoring. 10. If after repetitive suicidal ideation's or the need for 1:1 supervision, it becomes evident that the facility cannot provide adequate supervision and safety of the resident or others, the interdisciplinary team in partnership with the physician and psych services should consider alternate placement. 11. In the event that the resident is determined to need continuous observation until a longer term plan is implemented or emergency personnel are summoned, 1:1 supervision or indirect supervision through video observation may be used as indicated and compliant with appropriate consents and HIPPA requirements. The immediate jeopardy that began on 7/1/20, was removed on 7/15/20, when the facility reviewed their policies/procedures and ensured all staff would be trained in how to manage residents who may be at risk of harming themselves, prior to beginning their next shift. However, the noncompliance remained at the lower scope and severity level of a D- isolated incident with no actual harm with potential for more than minimal harm. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure resident's who are at risk of self-harm are protected. The director of nursing or designee, could conduct random audits of the	2 830		

Minnesota Department of Health

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2 830	Continued From page 17 delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		