Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL20076007M
Compliance Report#: HL20076008C

Date Concluded: March 9, 2021

Name, Address, and County of Licensee Investigated:
Pioneer Home Inc.
1131 South Mabelle Ave
Fergus Falls, MN 56537
Ottertail County

Name, Address, and County of Housing with Services location:
Pioneer Care Memory Cottage
521 Oak Street
Breckenridge, MN 56520
Wilkin County

Facility Type: Home Care Provider

Investigator's Name:
Jana Wegener RN, Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged a facility staff member, the alleged perpetrator (AP), verbally and physically abused a client causing a skin tear to the client's arm.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility and alleged perpetrator (AP) were responsible for the maltreatment. Multiple staff witnessed the AP over several months repeatedly verbally abuse the client by yelling, swearing at, and threatening to punch the client. The AP physically abused the client by punching him in the chest, pushing, kicking, and grabbing his arm causing a skin tear. The facility staff failed to protect the client and other vulnerable adults in the facility by allowing the AP to remain in the building and provide direct care for an additional six hours after staff witnessed the abuse.

The investigation included interviews with facility staff members, including administrative and nursing staff. The client's medical records, facility incidents, policy and procedures, and staff training were reviewed. In addition, law enforcement was contacted.

A review of client's medical record indicated the client had cognitive impairment with behaviors related to Alzheimer's disease and dementia and had the potential to be aggressive when feeling irritated or threatened. The client required assistance from others to make decisions, and frequently wandered around the facility independently.

The clients care plan interventions instructed staff to listen and respond with empathy, stand out of reach of the client, and encourage the client to take calm centering breaths. The care plan interventions also included removing the client from sources of distress and allow him to express his feelings towards the situation.

A review of the facility incident report indicated unlicensed staff reported to management that during the previous night shift she witnessed the AP physically and verbal abuse the client by hitting him in the chest, kicking him in the shin, repeatedly pushing him, and then grabbed his arm causing a skin tear. During the altercation, the unlicensed staff recorded the AP repeatedly yelling, swearing at, and threatening the client.

When interviewed the witnessed stated the AP was inpatient, short tempered, and verbally aggressive with the client(s) every night she worked with the AP over the last five to six months. The witness didn't report the ongoing, recurring verbal abuse because the AP "was not swearing" at the client. During the night of the incident, the client was trying to get a female client to walk with him. The AP yelled at the client in a loud aggressive tone, "She [female client] is not going anywhere with you." The client became agitated and hit the AP in the back of the head. The AP shoved the client backwards, kicked him in the shin, and hit him in the chest. The physical altercation between the AP and the client continued for approximately ten minutes until the AP grabbed the client's arm and caused a skin tear. When the client noticed his arm was bleeding, he backed away from the AP. The witness attempted to remove the client and told the AP to leave the client alone, but the AP continued "egging" on the client which caused the client to become more agitated. The witness stated she reported the abuse to management when the AP became physically abusive towards the client causing a skin tear.

A review of the witness audio recordings taken during the incident included five separate recordings varying in length from 19 to 49 seconds long. The AP was heard saying, "Oh god how I want to punch him [client], he is bringing out the old me", and repeatedly shouting at the client "Don't even think about it, no one wants you here, I will tackle you buddy, don't even think I won't!" The client was heard with a soft incoherent speech in the background. The AP responded in a loud voice at the client "what, what, what", repeating what the client had just softly said by stating in a loud mocking low tone "let her be" with a huffing noise, then shouting back at the client "You let her be"! The client's soft incoherent speech was heard again in the background, and the AP shouted at the client "She is not going anywhere with you, I am her boss, I will knock you out you stupid Fuck, don't even think about it tomboy, I can take your ass don't even think I can't!"

Review of the AP's personnel file indicated approximately six months prior to the physical and verbal altercation with the client, the AP was suspended for inappropriate verbal language toward another client because she felt irritated. After receiving verbal coaching the AP returned to work. There was no further documentation in the employees record regarding additional training or monitoring after the AP was disciplined for being irritated and using inappropriate language toward a client.

When interviewed staff stated she worked with AP on the overnight shifts and the AP raised her voice when speaking to the client. The AP would grab the clients arm and place her other arm behind his back and physically push the client against his will down the hallway towards his room. The client would get upset and start to swing at the AP and the AP would yell at the client "if you don't stop, I am going to punch you!" The staff member stated the verbal abuse and aggressive behavior between the AP and the client happened every night she worked with the AP. The unlicensed staff stated she never reported the ongoing verbal abuse to anyone at the facility.

When interviewed the facility nurse stated staff witnessed the AP hitting the client which caused a v shaped skin tear measuring 1.8 centimeters (cm) by 2 cm on the clients left forearm. The nurse stated she assessed the clients skin tear on his arm, however, she did not complete a full body assessment on the client to look for bruising or other injuries.

When interviewed facility administration stated the ongoing abuse of the client was not reported by staff and should have been. The night of the incident the witness should have called the nurse on call to come in and replace the AP for the remainder of her shift. The incident should have been immediately reported and investigated.

When interviewed the alleged perpetrator denied the allegations of abuse.

In conclusion, abuse was substantiated.

Abuse: Minnesota Statutes section 626.5572, subdivision 2

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The AP no longer works at the facility. All staff reviewed the licensee reporting policies and procedure, and some staff reviewed the Dementia Management and Abuse Prevention Training.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc: The Office of Ombudsman for Long-Term Care
Minnesota Board of Nursing
Wilkin County Attorney
Breckenridge Police Department
Breckenridge City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20076	A. BUILDING: _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER HOME INC - CARE SUITES	1006 SOUTH SHERIDAN FERGUS FALLS, MN 56537

(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
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On February 5, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL20076008C/#HHL20076007M. At the time of the investigation, there were #12 clients receiving services under the comprehensive license. The following correction orders are issued for #HL20076008C/#HL20076007M, tag identification 0265, 0325, 0805, 0810, 0865, 1187, 1190, and 2015.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 265 SS=I	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1.Statement of rights. (a) A client who	0 265		

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0 265	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide services according to accepted standards of medical, nursing, and health care practices for three of three clients, C1, C2, and C3, reviewed regarding staff treatment and acceptable standards of practice. Facility staff reported ULP-A was verbally abusive to C1, C2, and C3, and was not following the specific needs for the clients. ULP-A continued to work with clients. This lead to actual harm for C1 when ULP-A verbally and physically abused the client resulting in the client receiving a skin tear to his arm from ULP-A. This had the potential to effect all 12 clients residing in the memory care unit who ULP-A provided care for. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).	0 265		

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0 265	Continued From page 2 Findings include: C2 was admitted to the facility on January 13, 2017, and had diagnoses including epilepsy (a neurological disorder marked by episodes of loss of consciousness, or convulsions), dementia, and generalized arteriosclerosis (deposition of plaques of fatty material on their inner walls of blood vessels). C2's care plan dated May 29, 2020, indicated the client had cognitive impairment and required assistance with activities of daily living including dressing, bathing, bed mobility, transfers, positioning, and personal hygiene. The care plan indicated C2 was unaware of her surroundings and was unable to verbalize her needs at times . A review of the facility incident report and internal investigation dated May 4, 2020, at 2:00 a.m. indicated C2 had been up several times that night and unlicensed personal (ULP)-A swore and yelled at C2, "Go to bed god damit!" The investigation indicated ULP-A was suspended pending investigation, and the facility filed a vulnerable adult report with MAARC (the state reporting system). The facility document, Employee Warning Form, Written Warning, dated May 4, 2020, indicated ULP-I reported ULP-A used inappropriate tone and language towards C2. The document indicated on June 10, 2020, over a month after the alleged incident, ULP-A was coached to reach out to a coworker if she felt frustrated and was allowed to return to work. During interview on February 23, 2021, at 9:20 a.m. registered nurse clinical manager (RNCM)-F stated ULP-A had swore at a client in the past.	0 265		

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0 265	Continued From page 3 ULP-A was disciplined, and denied swearing or being rude to C2. On February 24, 2021, at 8:55 a.m. during a phone interview the Administrative Assistant (AA)-G stated on May 4, 2020, ULP-A swore at C2 "go to bed god damit", resulting in disciplinary action. AA-G stated following the incident the facility administration had planned to meet with ULP-A within 30 days. They interviewed other staff and casually asked staff how things were going with ULP-A. AA-G indicated ULP-A was instructed to reach out to another staff person if she was feeling frustrated. AA-G stated she did not follow up with ULP-A to see if she has felt frustrated, nor did she specifically reach out to ULP-A co-workers regarding ULP-A's treatment of clients. AA-G stated they did not monitor ULP-A after the May 4, 2020 incident, completed no audits of ULP-A's work performance and treatment of clients, and ULP-A received no re-education or training following the incident. AA-G stated the same night (May 4, 2020), staff also reported ULP-A treated another client, C3, rough and laughed at the client when she expressed pain. AA-G stated ULP-A denied the incident and it was not reported to the state agency and no further investigation was done. C3 was admitted to the facility on October 23, 2019, with diagnosis including Alzheimer's disease, chronic pain syndrome, impaired visual function, and major depressive disorder. C3's care plan dated October 23, 2019, indicated C3 was cognitively impaired and required staff assistance with ADL's including dressing, bathing,eating, personal hygiene, and transfers. C3 could move independently when in bed. The care plan indicated C3 was visually impaired and	0 265		

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0 265	Continued From page 4 instructed staff to knock on the door prior to entering, address C3 by name, and tell her who you are any why you are there. The care plan indicated C3 could become physically aggressive with cares and instructed staff to speak to her in a calm tone. C3's progress note dated June 5, 2020, at 11:19 a.m. indicated on the previous shift May 4, 2020, at 5:45 a.m. while staff were rolling the client in bed she accidentally hit her head on the wall. C3 had no noted bruising. A review of a hand written note written by ULP-I dated May 4, 2020, and given to AA-G indicated while providing cares to C3 with ULP-A, ULP-A pushed C3's shoulders so hard and fast C3 hit her left forehead on the wall, and ULP-A laughed at C3. ULP-A indicated she had told ULP-A it was not funny and ULP-A laughed and stated she was sorry but it [C3 hitting her head] was just so funny. The facility Incident Report dated May 4, 2020, indicated two staff [ULP-I and ULP-A] were assisting C3 with personal hygiene cares in bed and C3 accidentally bumped her head on the wall. The incident report lacked any of the initial internal report information provided by ULP-I's hand written note regarding ULP-A's rough handling or laughing at C3, and had no evidence an investigation was completed. When interviewed on February 19, 2021, at 11:00 a.m. ULP-I stated stated she reported ULP-A for abuse in May 2020, for yelling at a client "go to bed god damit", and also while she was providing personal hygiene cares to C3, ULP-A entered the clients room unannounced and abruptly shoved C3's upper body so hard and fast it caused the	0 265		

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0 265	Continued From page 5 C3 to hit her head on the wall. ULP-A started to laughed at C3 and ULP-I stated she told ULP-A it was not funny and she was being mean. ULP-A responded and stated she was sorry, but it [C3 hitting her head] was just so funny. During interview on February 24, 2021, at 8:55 a.m. AA-G stated she recalled the incident with C3 and ULP-A. She found about it when ULP-I left a note for her regarding the incident. AA-G stated ULP-A turned C3 hard and fast causing C3 to hit her head on the wall, and then ULP-A laughed at C3 and said it was funny. AA-G stated she had no documentation of an investigation, however, she recalled talking to the staff involved over the phone. AA-G stated ULP-A had no re-education or coaching following the incident with C3. AA-G stated ULP-A denied the incident happened, and only two staff were involved so it was one staff members word against another. AA-G stated the alleged incident with ULP-A and C3 happened the same night ULP-A received disciplinary action for swearing at C2 "go to bed god damit." During interview on February 23, 2021, at 9:20 a.m. RNCM-F stated she reviewed the incident report regarding C3 hitting her head on the wall. RNCM-F stated she was not aware ULP-I reported ULP-A pushed C3 over hard and fast causing her to hit her head on the wall and then laughed at C3. RNCM-F stated based on the incident report she thought C3 hit her head on the wall due to the position of the bed. C1 was admitted to the facility July 11, 2017, with diagnoses including Alzheimer's disease, dementia with behavioral disturbances, and asthma.	0 265		

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0 265	Continued From page 6 C1's care plan revised September 7, 2020, indicated cognitive impairment with behaviors related to Alzheimer's disease and dementia, and had the potential to be aggressive when feeling like he is being threatened. C1's care plan interventions instructed staff to listen to C1 and respond with empathy, stand out of reach, and encourage C1 to take calm centering breaths. The care plan interventions also included removing C1 from sources of distress, allow the client to express his feelings towards the situation, and/or call his daughter. A facility incident report dated October 31, 2020, at 7:30 a.m. indicated ULP-B reported during the night shift October 30, 2020, around 2:00 a.m. she witnessed ULP-A physically and verbally abused C1. ULP-A hit C1 in the chest, kicked him in the shin, repeatedly pushed him, and then grabbed his arm causing a skin tear. During the altercation ULP-B recorded five audio recordings on her cellular phone of ULP-A repeatedly yelling, swearing at, and threatening C1. C1's progress note dated October 31, 2020, at 12:48 p.m. indicated facility staff reported C1 and another individual were involved in an incident where C1 was hit in the chest, pushed, and kicked in the shin. The progress note indicated C1 received a skin tear and stopped the altercation on his own occurrence. C1 had no recollection of the incident, and no other injuries were noted. C1's skin assessment completed on October 31, 2020, at 12:08 p.m. identified a v shaped skin tear measuring 1.8 centimeters (cm) by 2 cm on the C1's left forearm. A review of the facility provided audio recordings	0 265		

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0 265	Continued From page 7 obtained by ULP-B during the night shift of October 30, 2020, during the incident between ULP-A and C1. There were five separate recordings ranging from 19 to 49 seconds long. ULP-A was heard in the recordings saying "Oh god how I want to punch him [C1], he is bringing out the old me", and repeatedly shouting at C1 "Don't even think about it, no one wants you here, I will tackle you buddy, don't even think I won't"! C1 was heard with a soft, incoherent speech in the background; ULP-A responded by shouting "What, what, what"! and repeating what C1 had softly said by stating "Let her be" in a loud, mocking, low tone and than shouted, "You let her be"! C1's soft incoherent speech was heard again in the background and ULP-A shouted "She is not going anywhere with you, I am her boss, I will knock you out you stupid Fuck, don't even think about it tomboy; I can take your ass don't even think I can't"! ULP-B was not heard intervening to protect C1 during any of the recordings. The undated facility Investigation of Suspected Maltreatment, included the internal incident report from October 30, 2020, and documentation of phone interviews with ULP-B, and ULP-A. ULP-B's initial report was made on 10/31/20, at 7:30 a.m. and indicated ULP-A was suspended pending investigation. The summary of the undated facility investigation findings indicated ULP-A and ULP-B had given two different stories of what had happened and ULP-A denied the incident occurred. The summary identified ULP-B had supporting evidence of the audio recordings with verbal inappropriateness and vulgar language towards C1, and ULP-A was terminated on November 2, 2020. During interview on February 18, 2021, at 4:45 p.m. ULP-B stated ULP-A was routinely inpatient	0 265		

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0 265	Continued From page 8 and short tempered with C1 and was verbally aggressive every night she worked over the last five to six months. ULP-B stated ULP-A yelled at C1 stating things like get the hell out of here, go to your room, and no body wants you here. ULP-B stated she never reported the ongoing recurring verbal abuse of C1 because ULP-A was not swearing at C1. ULP-B stated on October 31, 2020, at approximately 2:00 a.m. C1 was trying to get C2 to go with him. ULP-A was sitting next to C2 on the couch and was yelling at C1 that C2 was not going anywhere with him [C1]. ULP-B stated C1 became agitated and hit ULP-A in the back of the head, ULP-A shoved C1 backwards, kicked him in the shin, and hit him the chest. ULP-B stated the physical altercation continued back and forth between C1 and ULP-A for approximately ten minutes. ULP-A grabbed C1's arm and caused a five to six inch skin tear. ULP-B stated when C1 noticed his arm bleeding he backed away from ULP-A. ULP-B stated C1 was hurt at that point, and when she tried to get C1 away from ULP-A, ULP-A continued "egging" C1 on to agitate him. ULP-B stated she felt like it was an unsafe situation for C1. ULP-B stated she told ULP-A not to hit C1 and ULP-A stated C1 hit her first and she was going to "knock his ass to the ground," and didn't care if she "got fired." ULP-B stated she did not report the physical and verbal abuse until the following day after her shift ended, and did not think about calling a supervisor or 911 immediately when the altercation became physical. ULP-B stated ULP-A remained in the facility and worked her shift because they were the only two staff in the building. ULP-B stated she recorded and reported the verbal abuse when ULP-A became physically abusive towards C1 because she wanted her supervisor to believe her.	0 265		

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0 265	Continued From page 9 During interview on February 19, 2021, at 11:00 a.m. ULP-I stated she worked with ULP-A on the overnight shifts and ULP-A always yelled at C1. ULP-A would also grab C1's arm, and put her other arm behind his back and physically push him against his will down the hallway towards his room. ULP-I stated C1 would get upset and start to swing at ULP-A. ULP-A would yell at C1 if he didn't stop she would punch him. ULP-I stated the verbal abuse and aggressive behavior between ULP-A and C1 happened every night she worked. ULP-I stated she considered ULP-A's verbally aggressive behavior abusive, but indicated she had never thought about reported the ongoing verbal abuse. During interview on February 23, 2021, at 9:20 a.m. RNCM-F stated staff should call any time day or night to report a fall, skin tear, or bruise. RNCM-F stated C1 allowed her to look at the skin tear on his arm following the incident, but she did not do a full body assessment to look for bruising or other injuries due to C1's refusal. During interview on February 24, 2021, at 11:26 a.m. registered nurse housing director (RNHD)-E stated she investigated and reviewed incidents that occurred. RNHD-E stated she recalled the incident on May 4, 2020, and indicated ULP-A and ULP-I rolled C3 during cares and C3 bumped her head on the wall by accident. RNHD-E stated C3's bed was against the wall and they moved the bed away from the wall. RNHD-E stated AA-G and RNCM-F had reviewed that incident. RNHD-E stated she had no knowledge of the allegation ULP-A had pushed C3 into the wall and laughed at C3. RNHD-E stated on May 4, 2020, ULP-A was suspended for another incident when she swore at C2, and indicated the information involving the incident was on the same night as	0 265		

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0 265	Continued From page 10 the allegation regarding C3. RNHD-E stated she was unaware of any other incidents involving ULP-A when she was suspended following the incident with C2. ULP-A stated following the May 4, 2020, incident staff involved were interviewed, but indicated she thought Ottertail County would investigate the incident. RNHD-E stated she did not feel comfortable with ULP-A at work and was waiting for someone to investigate from the county, and felt they needed to make a decision regarding ULP-A's suspension. ULP-A received disciplinary action, verbal coaching, and was allowed to return to work. RNHD-E stated she felt there were some personality conflicts among staff, and ULP-A denied the incident so it was "her word against her word". RNHD-E indicated she was unaware staff had concerns regarding ULP-A verbally abusing C1 routinely for the past 5-6 months. RNHD-E stated following the October 30, 2020, incident when ULP-B had recorded ULP-A verbally abuse C1, ULP-A was suspended, and then terminated. RNHD-E stated ULP-B did not report the abuse until the following morning, and ULP-A continued to work until the end of her shift. RNHD-E stated ULP-B should have called the RN on call, and the RN oncall should have come in and relieved ULP-A of her duties. The facility policy titled Reporting Documenting and Reviewing Incidents Involving Residents, effective November 2014, instructed staff to respond quickly with incidents involving a resident to prevent further harm, and document incidents involving the residents including staff response. Section 1. instructed staff to take emergency actions when necessary and complete an incident report. Section 2. indicated if the incident must be reported to MAARC, staff will do so as soon as possible but no later than 24 hours after the	0 265		

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0 265	Continued From page 11 incident, and the RN or housing director would immediately begin an investigation. Section 6. indicates immediate actions should be taken to prevent similar incidents and implement actions including additional staff training if necessary. The reporting policy review by staff lacked guidance for staff to define the different types of abuse, how to recognize abuse, and specific steps on what to do if abuse occurred, or staff competencies. No additional information was provided. Time period for correction: Seven (7) days.	0 265		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observation, interviews, and document review, the facility failed to ensure client one, (C1) was free from maltreatment. Findings include: On February 5, 2021, the Minnesota Department of Health (MDH) issued a determination that	0 325	No Plan of Correction (PoC) is required. Please refer to the public maltreatment report for details.	

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0 325	Continued From page 12 abuse occurred. The MDH concluded there was a preponderance of evidence that maltreatment occurred, and an individual staff person, and the facility, were responsible for the maltreatment in the facility.	0 325		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility staff failed to immediately report ongoing suspected abuse for two of three clients (C1, and C3) reviewed regarding allegations of abuse. Staff witnessed a coworker repeatedly verbally abuse C1 over several months and failed to report it leading up to C1 being physically abused. The facility staff indicated they observed a staff member physically abuse C1 and allowed the staff member to continue working and did not report the abuse until the end of their work day. Additionally, the facility failed to investigate and report allegation of abuse to the Minnesota Adult Abuse Reporting Center (MAARC) when staff report observing a coworker treating C3 roughly during cares and laughing after hurting the client.	0 805		

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0 805	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1 was admitted to the facility July 11, 2017, with diagnoses included Alzheimer's disease, dementia with behavioral disturbances, and asthma. C1's care plan revised September 7, 2020, indicated no cognitive impairment with behaviors related to Alzheimer's disease and dementia. C1 had the potential to be aggressive when he felt threatened. C1's care plan interventions instructed staff to listen to C1 and respond with empathy, stand out of reach, and encourage C1 to take calm centering breaths. The care plan interventions also included removing C1 from sources of distress, allow him to express his feelings towards the situation, or call his daughter. C1's progress note dated October 31, 2020, at 12:48 p.m. indicated facility staff reported C1 and a staff member were involved in an incident where the staff member hit C1 in the chest, pushed him, and kicked him in the shin. The progress note indicated C1 received a skin tear and stopped the altercation on his own occurrence. C1 had no recollection of the incident, and no other injuries were noted.	0 805		

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0 805	Continued From page 14 C1's skin assessment completed on October 31, 2020, at 12:08 p.m. identified a v shaped skin tear measuring 1.8 centimeters (cm) by 2 cm on the C1's left forearm. A review of the facility incident report dated October 31, 2020, at 7:30 a.m. indicated unlicensed personnel (ULP)-B reported to facility administration staff that during the night shift October 30, 2020, around 2:00 a.m. she witnessed unlicensed personal (ULP)-A physically and verbally abused C1 by hitting him in the chest, kicking him in the shin, repeatedly pushing him, and then grabbed his arm causing a skin tear. During the altercation ULP-B recorded five audio recordings on her cellular phone of ULP-A repeatedly yelling, swearing at, and threatening C1. A review of the facility provided audio recordings obtained by ULP-B during the night shift of October 30, 2020, during the incident included five separate recordings each one 19 to 49 seconds long. ULP-A was heard in the recordings saying "Oh god how I want to punch him, he is bringing out the old me", and repeatedly shouting at C1 "Don't even think about it, no one wants you here, I will tackle you buddy, don't even think I won't"! The client was heard with a soft incoherent speech in the background and ULP-A responded by shouting at C1 "What, what, what"! and repeating what C1 had softly said by stating "Let her be" in a loud mocking low tone then shouting back at C1 "You let her be"! C1's soft incoherent speech was heard again in the background and ULP-A shouted "She is not going anywhere with you, I am her boss, I will knock you out you stupid Fuck, don't even think about it tomboy I can take your ass don't even think I can't"! ULP-B was not heard intervening during	0 805		

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0 805	Continued From page 15 any of the recordings. A review of facility provided document titled "Investigation of Suspected Maltreatment", included the internal incident report and documentation of phone interviews with unlicensed personnel (ULP)-B, and ULP-A and indicated ULP-B's initial report was made on 10/31/20, at 7:30 a.m. and indicated ULP-A was suspended pending investigation. The summary of the undated facility investigation findings indicated ULP-A and ULP-B had given two different stories of what had happened. ULP-A denied the incident occurred. The summary identified ULP-B had supporting evidence of the audio recordings of ULP-A being verbally inappropriate and using vulgar language towards C1. During interview on February 18, 2021, at 4:45 p.m. ULP-B stated ULP-A was routinely inpatient and short tempered with C1 and had become verbally aggressive every night she worked with her over the last five to six months. ULP-B stated ULP-A yelled get the hell out of here, go to your room, and no body wants you here to C1. ULP-B stated she never reported the ongoing recurring verbal abuse of C1 because ULP-A was not swearing at C1. ULP-B stated on October 31, 2020, at approximately 2:00 a.m. C1 was trying to get a female client to go with him, while ULP-A sat on the couch next to the client and yelled at C1 the other client was not going anywhere with him. ULP-B stated C1 became agitated when ULP-A yelled at him and C1 hit ULP-A in the back of the head, ULP-A shoved C1 backwards, kicked him in the shin, and hit him the chest. ULP-B stated the physical altercation between ULP-A and C1 continued back and forth for approximately ten minutes until ULP-A grabbed	0 805		

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0 805	Continued From page 16 C1's arm and caused a five to six inch skin tea on C1's arm. ULP-B stated when C1 noticed his arm was bleeding he backed away from ULP-A. ULP-B stated she attempted to remove C1 away from ULP-A, and ULP-A kept "egging" C1 on saying things to agitate him. ULP-B stated she told ULP-A not to hit C1, and leave him alone and ULP-A stated I don't care if I knock his ass to the ground or get fired. ULP-B stated she did not immediately report the physical and verbal abuse that occurred that night until the following day after her shift ended, and did not think about calling a supervisor or 911 immediately. ULP-B stated ULP-A remained in the facility and worked her shift because they were the only two staff in the building. ULP-B stated she recorded and reported the verbal abuse when ULP-A became physically abusive towards C1 because she wanted her supervisor to believe her. ULP-B stated she had abuse training last year but indicated she did not remember what to do in those situations. On February 19, 2021, at 11:00 a.m. during a phone interview ULP-I stated she worked with ULP-A on the overnight shifts and ULP-A always yelled at C1 and would grab his arm and put her other arm behind his back and physically push him against his will down the hallway towards his room. ULP-I stated C1 would get upset and start to swing at ULP-A and ULP-A would yell at C1 to stop or she would punch him. ULP-I stated the verbal abuse and aggressive behavior with ULP-A and C1 happened every night she worked. ULP-I stated she considered ULP-A's verbally aggressive behavior abusive, but indicated she had never thought about reporting the ongoing verbal abuse. ULP-I stated if a client was being abused she would report it to her supervisor the next day when they were working. ULP-I indicated	0 805		

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0 805	Continued From page 17 they had emergency on call staff available 24 hours a day, seven days a week to report any alleged abuse to. On February 23, 2021, at 9:20 a.m. during a phone interview with registered nurse clinical manager (RNCM)-F stated staff can call any time day or night to report allegations of abuse. RNCM-F stated she was called on October 31, 2021, at approximately 7:00 a.m. and told there was an altercation that occurred between ULP-A and C1. RNCM-F stated ULP-B had witnessed ULP-A hitting C1 and caused a skin tear on his arm. RNCM-F stated staff did not recognize the incident between C1 and ULP-A abusive. C3 was admitted to the facility on October 23, 2019, with diagnosis including Alzheimer's disease, chronic pain syndrome, impaired visual function, and major depressive disorder. C3's care plan dated October 23, 2019, indicated C3 was cognitively impaired and required staff assistance with ADL's including dressing, bathing, eating, personal hygiene, and transfers. C3 was visually impaired and staff were instructed to knock on the clients door prior to entering, address C3 by her name, and tell the client who you are and why you are there. C3's progress note dated June 5, 2020, at 11:19 a.m. indicated on May 4, 2020, at 5:45 a.m. while staff were rolling C3 in bed to provide incontinence cares, the client hit her head on the wall. The progress note indicated C3 had no bruising or visible injury. A hand written note dated May 4, 2020, indicated ULP-I was providing cares for C3. ULP-A came into C3's room to assist. ULP-A pushed the	0 805		

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0 805	Continued From page 18 clients shoulders, "so hard and fast," the client hit her left forehead on the wall. ULP-A laughed after the C3's head hit the wall. ULP-I told ULP-A it was not funny and ULP-A replied laughing, "I am sorry but that was just so funny!" The facility Incident Report dated May 4, 2020, indicated two staff, ULP-I and ULP-A, were assisting C3 with personal hygiene cares in bed and turned C3 onto her side when the client accidentally bumped her head on the wall. The incident report lacked any of the initial internal information of the incident provided by ULP-I's hand written note regarding ULP-A's rough handling or laughing at C3. During interview on February 19, 2021, at 11:00 a.m. ULP-I stated she was providing personal hygiene cares to C3. Although ULP-I stated she didn't request assistance, ULP-A entered C3's room unannounced and abruptly shoved C3's upper body so hard and fast it caused the client to roll into the wall and hit her head. ULP-I stated when C3 hit her head on the wall ULP-A laughed at C3. ULP-I stated she told ULP-A it was not funny and it was mean, ULP-A responded, "I am sorry but that was just so funny." ULP-I stated she wrote a note regarding the incident and left it for administrative assistance (AA-G). During interview on February 24, 2021, at 8:55 a.m. AA-G stated ULP-I left her a note regarding the alleged incident of ULP-A turning C3 fast and hard, resulting in the client hitting her, and ULP-A laughing at the client. AA-G stated she had no documentation of an investigation being done; however, she stated she spoke to the staff involved and ULP-A denied the incident happened. AA-G stated there were only two staff involved and they both had different story's so a	0 805		

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0 805	Continued From page 19 vulnerable adult report was not made to MAARC. During interview on March 1, 2020, at 1:31 p.m. Registered Nurse Clinical Manager (RNCM)-F stated she reviewed the incident report regarding ULP-A and C3, but she was not aware ULP-I had initially reported the incident regarding C3 and ULP-A. RNCM-F stated she did not recall interviewing staff regarding the information on the incident report because C3 had no injury on her head, and she thought it was an issue with the clients bed being positioned against the wall. During interview on February 24, 2021, at 11:26 a.m. Registered Nurse Housing Director (RNHD)-E stated she was responsible to review all incidents that occur in the facility. RNHD-E stated an internal investigation should be done to determine if maltreatment occurred, and based off those findings a report is made to MAARC. RNHD-E stated she recalled the incident on May 4, 2020, and indicated C3 accidentally bumped her head on the wall during cares. RNHD-E stated she had no knowledge of the allegation ULP-A treated C3 rough when she pushed her hard and fast causing her head to hit the wall and ULP-A laughed at the client. RNHD-E stated she though C3's bed was too close to the wall and needed to be moved. RNHD-E stated she would expect complete information to be included on the incident report, and the incident should be investigated and reported to MAARC. The facility policy titled Vulnerable Adult Reporting and Investigation, dated November 2014, indicated any staff who witnessed or suspected any form of maltreatment abuse must report the incident immediately to the registered nurse (RN) in charge or the housing director. The RN or Housing Director will complete an incident report.	0 805		

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0 805	Continued From page 20 The facility policy titled Reporting Documenting and Reviewing Incidents Involving Residents, effective November 2014, indicated staff would complete an incident report. Section 2. indicated if the incident must be reported to MAARC, the housing director or staff would do so as soon as possible but no later than 24 hours after the incident, and immediately begin an investigation. No additional information was provided. Time Period for correction: Fourteen (14) days.	0 805		
0 810 SS=F	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the individual abuse prevention plans reflected the current needs for 3 of 3 clients, C1, C2, and C3, of abuse prevention plans were reviewed. The facility failed to	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 21 updated C1, C2, and C3 individual abuse prevention plans to contain all areas of vulnerability and/or included statements of the specific measures to be taken to minimize the risk of abuse to the client. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: C1 was admitted to the facility July 11, 2017, with diagnoses included Alzheimer's disease, dementia with behavioral disturbances, and asthma. C1's care plan revised September 7, 2020, indicated the client had cognitive impairment with behaviors related to Alzheimer's disease and dementia, and had the potential to be aggressive when he felt threatened. C1's care plan interventions instructed staff to listen to C1 and respond with empathy, stand out of reach, and encourage C1 to take calm centering breaths. The care plan interventions also included removing C1 from sources of distress, allow him to express his feelings towards the situation, and/or call his daughter. The facility incident report dated October 31, 2020, at 7:30 a.m. indicated during the night shift on October 30, 2020, unlicensed personnel (ULP)-B witnessed a coworker, ULP-A physically and verbally abuse C1. ULP-A hit C1 in the	0 810		

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0 810	Continued From page 22 chest, kicked C1 in the shin, repeatedly pushed C1, and grabbed the clients arm causing a skin tear. C1's only vulnerability assessment (completed on admission) dated July 11, 2017, and titled Assessment for Vulnerability, and Safety Risk for Others, indicated C1 was oriented to time, self, and place. The assessment also indicated C1 was hard of hearing but was able to understand, follow directions, and could give accurate information consistently. At the time of the vulnerability assessment, C1 had no areas of vulnerability requiring intervention. There were no subsequent vulnerability assessments completed to identify C1's vulnerability leading up to, or immediately following, the October 30, 2020 incident. On February 9, 2021, C1's vulnerability assessment was updated and indicated the client was oriented only to himself, was not able to understand or give accurate information, and was unable to follow directions. C1 utilized medications for sleep and agitation, and identified interventions staff could utilize. The assessment also indicated C1 was protective over another female client in the facility, and he may pose a risk to other vulnerable adults. C2 was admitted to the facility on January 13, 2017, and had diagnoses including epilepsy (a neurological disorder marked by episodes of loss of consciousness, or convulsions), dementia, and generalized arteriosclerosis (deposition of plaques of fatty material on their inner walls of blood vessels). C2's care plan dated May 29, 2020, indicated she was cognitively impairment and required	0 810		

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0 810	Continued From page 23 assistance with activities of daily living including dressing bathing, bed mobility, transfers, positioning and personal hygiene. C2 was unaware of her surroundings and at times was unable to verbalize her needs. C2's only vulnerability assessment (completed on admission) dated January 13, 2017, Assessment for Vulnerability, and Safety Risk for Others, indicated C2 was oriented to time, self, and place. The assessment also indicated C2 was able to understand, follow directions, give accurate information consistently, and could report abuse or neglect. The client had no areas of vulnerability requiring intervention at that time. There were no subsequent vulnerability assessments completed to identify C2's vulnerability leading up to or immediately following the May 4, 2020 incident when C2 was verbally abused by ULP-A. A facility incident report dated May 4, 2020, at 2:00 a.m. indicated ULP-I witnessed ULP-A verbally abuse C2 when she yelled and swore at the client. ULP-A yelled at C2, "Go to bed god damit!" On February 9, 2021, C2's vulnerability assessment was updated four years after the last assessment was completed indicated she was not oriented, not able to understand or give accurate information, was unable to follow directions, and would be unable to identify or report abuse or neglect. The assessment also indicated C2 did not stay in her bed at night and was usually up wandering around the facility until she fell asleep on the couch or in a chair. C3 was admitted to the facility on October 23, 2019, with diagnosis including Alzheimer's	0 810		

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0 810	Continued From page 24 disease, chronic pain syndrome, impaired visual function, and major depressive disorder. C3's care plan dated October 23, 2019, indicated C3 was cognitively impaired and required staff assistance with ADL's including dressing, bathing,eating personal hygiene, and transfers. C3 could move independently when in bed. C3 was visually impaired and instructed staff to knock on the door prior to entering, address C3 by name, and tell her who you are and why you are there. The care plan indicated C3 could become physically aggressive with cares and instructed staff to speak to her in a calm tone. C3's vulnerability assessment completed on admission dated November 11, 2015, and titled "Assessment for Vulnerability, and Safety Risk for Others", indicated C3 was oriented to time, self, place, and could walk independently. The assessment also indicated C3 was able to understand and follow directions, and give accurate information consistently, could report abuse or neglect and indicated the client had no areas of vulnerability requiring intervention at that time. C3's re-admission vulnerability assessment dated October 23, 2019 indicated C3 was oriented to person and place, used a wheelchair for mobility, wore glasses, and was unable to communicate. The assessment indicated C3 was a potential risk to others and would strike out. There were no subsequent vulnerability assessments completed to identify C3's vulnerability leading up to or immediately following the May 4, 2020 incident. On February 19, 2021, at 11:00 a.m. during a phone interview ULP-I stated stated while she was providing personal hygiene cares to C3,	0 810		

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0 810	Continued From page 25 ULP-A entered the room unannounced and abruptly shoved C3's upper body so hard and fast it caused her to roll and hit her head on the wall. ULP-I stated when C3 hit her head in the wall ULP-A laughed at C3. ULP-I stated she told ULP-A that was not funny it was mean, and ULP-B responded oh I am sorry but that was just so funny. During a follow up interview RNCM-F stated she was responsible for completing client vulnerability assessments, and stated they were done on admission and return from the hospital. RNCM-F stated a quarterly assessment may trigger a vulnerability re-assessment if the client had changes. RNCM-F stated she had started about a year ago and indicated when answering questions in the quarterly assessments regarding changes that would prompt a vulnerability assessment, she answered based on her knowledge over the last year. RNCM-F stated she did not review the previous assessment and was not aware of when a previous vulnerability assessment had been completed to know if changes had occurred since the last assessment. RNCM-F stated an assessment should be done following a vulnerable adult report, but indicated she just did not think of it. RNCM-F stated there was no process for completing vulnerability assessments other than the quarterly prompts or the assessors determination to complete one. During written correspondence on February 16, 2021, at 4:31 p.m. the Registered Nurse Housing Director (RNHD) confirmed the facility provided vulnerability assessments for C1, and C2 were the only assessments completed before and following the maltreatment incidents. In addition, RNHD verified C3 had only admission and readmission vulnerability assessment completed.	0 810		

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0 810	Continued From page 26 The facility provided policy titled "Initial and Ongoing Nursing Assessment of Clients Under the Comprehensive Licensed Agency", and dated July 31, 2019, indicated indicated an initial assessment of the clients vulnerability and susceptibility to maltreatment would be completed for the clients individual abuse prevention plan and identified specific measures to be taken to minimize the risks of maltreatment to the client or other vulnerable adults. The policy indicated the clients would be re-assessed on an ongoing basis any time they returned from the hospital or nursing home stay, had a change in condition, or experienced an incident. No additional information was provided. Time Period for Correction: Fourteen (14) days.	0 810		
0 865 SS=G	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9.Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the	0 865		

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0 865	Continued From page 27 Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement the client's service plan for 2 of 3 clients, C1 and C3, who's service plans were reviewed. C3's cares were not completed according to the service plan, and C1 had specific, dementia care related needs to prevent agitation that was not implemented by staff. This resulted in harm for C1 when a staff member repeatedly failed to implement C1's service plan resulting in agitation for C1. In addition, other staff who repeatedly observed the service plan not being followed failed to intervene to ensure C1's service plan was followed. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 865		

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0 865	Continued From page 28 Findings include: C1 was admitted to the facility July 11, 2017, with diagnoses including Alzheimer's disease, dementia with behavioral disturbances, and asthma. C1's care plan revised September 7, 2020, indicated the client had cognitive impairment and behaviors related to Alzheimer's disease and dementia. C1 had the potential to be aggressive when he felt threatened. Staff were directed to listen to C1 and respond with empathy, stand out of the clients reach, and encourage C1 to take calm centering breaths. The care plan interventions also included removing C1 from sources of distress, allow him to express his feelings towards the situation, and/or call his daughter. C1's progress note dated October 31, 2020, at 12:48 p.m. indicated facility staff reported C1 and unlicensed personal (ULP)-A were involved in an incident. ULP-A hit C1 in the chest, pushed him, and kicked C1 in the shin. The progress note indicated C1 received a skin tear and stopped the altercation on his own occurrence. C1 had no recollection of the incident, and no other injuries were noted. During interview on February 18, 2021, at 4:45 p.m. unlicensed personal (ULP)-B stated ULP-A was routinely inpatient and short tempered with C1, and was verbally aggressive every night she worked over the last five to six months. ULP-B stated ULP-A yelled at C1 and would say things like, get the hell out of here, go to your room, no body wants you here! ULP-B stated on October 31, 2020, at approximately 2:00 a.m. C1 was trying to get C2 to go with him. ULP-A was sitting	0 865		

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0 865	Continued From page 29 on the couch next to C2 and was yelling at C1, "She [C2] is not going anywhere with you!" C1 became agitated and hit ULP-A in the back of the head. A review of the facility incident report dated October 31, 2020, at 7:30 a.m. indicated unlicensed personnel (ULP)-B reported to facility administration that during the night shift October 30, 2020, around 2:00 a.m. she witnessed ULP-A physically and verbally abuse C1 by hitting him in the chest, kicking him in the shin, repeatedly pushing him, and then grabbed his arm causing a skin tear. During interview on February 19, 2021, at 11:00 a.m. ULP-I stated she worked with ULP-A on the overnight shifts and ULP-A always yelled at C1 and would grab his arm, put her other arm behind his back, and physically push him against his will down the hallway towards his room. ULP-I stated C1 would get upset and start to swing at ULP-A. ULP-A would yell at C1 if he didn't stop she would punch him. ULP-I stated the verbal altercations between ULP-A and C1 happened every night ULP-A worked with ULP-A. C3 was admitted to the facility on October 23, 2019, with diagnosis including Alzheimer's disease, chronic pain syndrome, impaired visual function, and major depressive disorder. C3's care plan dated October 23, 2019, indicated C3 was cognitively impaired and required staff assistance with ADL's including dressing, bathing,eating and personal hygiene, and transfers, but could move independently when in bed. The care plan indicated C3 was visually impaired and instructed staff to knock on the door prior to entering, address C3 by name, and tell	0 865		

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0 865	Continued From page 30 the client who you are any why you are there. C3 could become physically aggressive with cares and instructed staff to speak in a calm tone. C3's progress note dated June 5, 2020, at 11:19 a.m. indicated on May 4, 2020, at 5:45 a.m. while staff were rolling her in bed to provide incontinence cares she accidentally hit her head on the wall, with no bruising noted. During interview on February 19, 2021, at 11:00 a.m. ULP-I stated she was providing personal hygiene cares to C3 when ULP-A entered the room unannounced and abruptly shoved C3's upper body so hard and fast it caused her to roll and hit her head on the wall. ULP-I stated when C3 hit her head in the wall ULP-A laughed at C3. ULP-I stated she told ULP-A that was not funny it was mean, and ULP-B responded oh I am sorry but that was just so funny. No additional information was provided. Time period for correction: Seven (7) days.	0 865		
01187 SS=F	144D.065 Training In Dementia Care Required 144D.065 TRAINING IN DEMENTIA CARE REQUIRED. (a) If a housing with services establishment registered under this chapter has a special program or special care unit for residents with Alzheimer's disease or other dementias or advertises, markets, or otherwise promotes the establishment as providing services for persons with Alzheimer's disease or other dementias, whether in a segregated or general unit, employees of the establishment and of the	01187		

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01187	Continued From page 31 establishment's arranged home care provider must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b), or a supervisor meeting the requirements in clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; (3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and	01187		

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01187	Continued From page 32 (4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subdivision 2, clause (4). (d) Housing with services establishments not included in paragraph (a) that provide assisted living services under chapter 144G must meet the following training requirements: (1) supervisors of direct-care staff must have at least four hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	01187		

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01187	Continued From page 33 at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial four hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or supervisor meeting the requirements under paragraph (a), clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; (3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and (4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of four employees (A, B, and K) received the required amount of dementia care training in the required time frame in accordance with 144D.065. This had the potential to affect all 12 clients residing in the	01187		

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PIONEER HOME INC - CARE SUITES	1006 SOUTH SHERIDAN FERGUS FALLS, MN 56537

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01187	Continued From page 34 facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: Unlicensed personnel (ULP)-A's personnel file indicated she was hired on July 15, 2019. ULP-A was terminated after an alleged incident of physical and verbal abuse involving a client in November, 2020. ULP-A's employee record indicated no required annual training for Alzheimer's/Dementia was completed during her employment. ULP-B was hired on November 17, 2018, and completed required Alzheimer's disease and related disorders training on hire November 18, 2018, and annually on May 22, 2019, and August 5, 2020 (3 months late). ULP-K was hired on June 19, 2017, and completed required Alzheimer's disease and related disorders training on November 1, 2018, May 9, 2019, August 5, 2020 (3 months late). On February 24, 2021, at 8:55 a.m. AA-G stated she was in charge of tracking and assigning required training and education to staff, and indicated it needed to be completed every calendar year, and was not aware it needed to be completed every 12 months of employment.	01187		

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01187	Continued From page 35 The undated facility provided policy and procedure titled "Dementia Program Disclosure Policy and Procedure", indicated under section "Categories of Employees Trained and Frequency of Training", indicated direct care staff must complete eight hours of initial training, and at least 2 hours of dementia training for each 12 months of employment thereafter. No additional information provided. Time period for correction: Fourteen (14) days.	01187		
01190 SS=F	144A.4796, Subd. 6 Required Annual Training Subd. 6.Required annual training. (a) All staff that perform direct home care services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services. The annual training must include: (1) training on reporting of maltreatment of minors under section 626.556 and maltreatment of vulnerable adults under section 626.557, whichever is applicable to the services provided; (2) review of the home care bill of rights in section 144A.44; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand-washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01190		

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01190	Continued From page 36 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of communicable diseases; and (4) review of the provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures. (b) In addition to the topics listed in paragraph (a), annual training may also contain training on providing services to clients with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research-based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure four of four employees,	01190		

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01190	Continued From page 37 unlicensed personal ULP-A, ULP-B, ULP-k, and ULP-L, reviewed for training had received a minimum of eight hours of training to include the required topics for each twelve months of employment as required with records reviewed. This had the potential to affect all 12 clients in the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: Unlicensed Personnel (ULP)-A's employee record indicated she was hired on July 15, 2019, to provide direct care to clients. Following an alleged incident of physical and verbal abuse to a client, ULP-A was terminated on November 2, 2020. ULP-A's employee record indicated required annual training was not completed during her employment. ULP-B was hired on November 17, 2018, to provide direct care to clients and completed required annual training on May 22, 2019, and October 26, 2020 (5 months late). ULP-K was hired on June 19, 2017, to provide direct care to clients and completed required annual training on November 5, 2018, May 9, 2019, and November 4, 2020 (6 months late). ULP-L was hired July 2, 2018, to provide direct care to clients and completed annual training on	01190		

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01190	Continued From page 38 July 16, 2019, and November 11, 2020 (4 months late). During interview on February 24, 2021, at 8:55 a.m. administrative assistant (AA)-G stated she was in charge of tracking and assigning required training and education to staff, and indicated the facility believed it needed to be completed every calendar year, and was not aware it needed to be completed every 12 months of employment. The facility policy and procedure titled "Annual In-Service Training", dated November 2014, indicated all home care staff must participate in required annual in-service training for each 12 months of employment. The policy indicated the housing director or person designated by the director was responsible for tracking healthcare staff members' in-service training and give staff members advanced notice if it appears they will not meet the requirement. No additional information provided. TIme period for correction: Seven (7) days	01190		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3.Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the	02015		

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02015	Continued From page 39 individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event	02015		

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02015	Continued From page 40 meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility staff failed to immediately report ongoing suspected abuse for two of three clients (C1, and C3) reviewed regarding allegations of abuse. Staff witnessed a coworker repeatedly verbally abuse C1 over several months and failed to report it leading up to C1 being physically abused by the staff member. The facility staff indicated they observed the staff member physically abuse C1 and allowed the staff member to continue working and did not report the abuse until the end of their work day. In addition, staff report observing another staff member treating C3 roughly during cares and laughing after hurting the client. The facility failed to investigate and report the allegation to the Minnesota Adult Abuse Reporting Center (MAARC). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1 was admitted to the facility July 11, 2017, with	02015		

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02015	Continued From page 41 diagnoses included Alzheimer's disease, dementia with behavioral disturbances, and asthma. C1's care plan revised September 7, 2020, indicated he had cognitive impairment with behaviors related to Alzheimer's disease and dementia. C1 had the potential to be aggressive when he felt threatened. C1's care plan interventions instructed staff to listen to C1 and respond with empathy, stand out of reach, and encourage C1 to take calm centering breaths. The care plan interventions also included removing C1 from sources of distress, allow him to express his feelings towards the situation, or call his daughter. C1's progress note dated October 31, 2020, at 12:48 p.m. indicated facility staff reported C1 and a staff member were involved in an incident where the staff member hit C1 in the chest, pushed him, and kicked him in the shin. The progress note indicated C1 received a skin tear and stopped the altercation on his own occurrence. C1 had no recollection of the incident, and no other injuries were noted. C1's skin assessment completed on October 31, 2020, at 12:08 p.m. identified a v shaped skin tear measuring 1.8 centimeters (cm) by 2 cm on the C1's left forearm. A review of the facility incident report dated October 31, 2020, at 7:30 a.m. indicated unlicensed personnel (ULP)-B reported to facility administration staff that during the night shift October 30, 2020, around 2:00 a.m. she had witnessed unlicensed personal (ULP)-A physically and verbally abused C1 by hitting him in the chest, kicking him in the shin, repeatedly pushing	02015		

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02015	Continued From page 42 him, and then grabbed his arm causing a skin tear. During the altercation ULP-B recorded five audio recordings on her cellular phone of ULP-A repeatedly yelling, swearing at, and threatening C1. A review of the facility provided audio recordings obtained by ULP-B during the night shift of October 30, 2020, during the incident included five separate recordings each one 19 to 49 seconds long. ULP-A was heard in the recordings saying "Oh god how I want to punch him, he is bringing out the old me", and repeatedly shouting at C1 "Don't even think about it, no one wants you here, I will tackle you buddy, don't even think I won't"! The client was heard with a soft incoherent speech in the background and ULP-A responded by shouting at C1 "What, what, what"! and repeating what C1 had softly said by stating "Let her be" in a loud mocking low tone then shouting back at C1 "You let her be"! C1's soft incoherent speech was heard again in the background and ULP-A shouted "She is not going anywhere with you, I am her boss, I will knock you out you stupid Fuck, don't even think about it tomboy I can take your ass don't even think I can't"! ULP-B was not heard intervening during any of the recordings. A review of facility provided document titled "Investigation of Suspected Maltreatment", included the internal incident report and documentation of phone interviews with unlicensed personnel (ULP)-B, and ULP-A and indicated ULP-B's initial report was made on October 31, 2020, at 7:30 a.m. indicated ULP-A was suspended pending investigation. The summary of the undated facility investigation findings indicated ULP-A and ULP-B had given two different stories of what had happened.	02015		

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02015	Continued From page 43 ULP-A denied the incident occurred. The summary identified ULP-B had supporting evidence of the audio recordings of ULP-A being verbally inappropriate and using vulgar language towards C1. During interview on February 18, 2021, at 4:45 p.m. ULP-B stated ULP-A was routinely inpatient and short tempered with C1 and had become verbally aggressive every night she worked with her over the last five to six months. ULP-B stated ULP-A yelled get the hell out of here, go to your room, and no body wants you here to C1. ULP-B stated she never reported the ongoing recurring verbal abuse of C1 because ULP-A was not swearing at C1. ULP-B stated on October 31, 2020, at approximately 2:00 a.m. C1 was trying to get a female client to go with him, while ULP-A sat on the couch next to the client and yelled at C1 the other client was not going anywhere with him. ULP-B stated C1 became agitated when ULP-A yelled at him and C1 hit ULP-A in the back of the head, ULP-A shoved C1 backwards, kicked him in the shin, and hit him the chest. ULP-B stated the physical altercation between ULP-A and C1 continued back and forth for approximately ten minutes until ULP-A grabbed C1's arm and caused a five to six inch skin tea on C1's arm. ULP-B stated when C1 noticed his arm was bleeding he backed away from ULP-A. ULP-B stated she attempted to remove C1 away from ULP-A, and ULP-A kept "egging" C1 on saying things to agitate him. ULP-B stated she told ULP-A not to hit C1, and to leave him alone and ULP-A stated "I don't care if I knock his ass to the ground or get fired". ULP-B stated she did not immediately report the physical and verbal abuse that occurred that night until the following day after her shift ended, and did not think about calling a supervisor or 911 immediately. ULP-B	02015		

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02015	Continued From page 44 stated ULP-A remained in the facility and worked her shift because they were the only two staff in the building. ULP-B stated she recorded and reported the verbal abuse when ULP-A became physically abusive towards C1 because she wanted her supervisors to believe her. ULP-B stated she had abuse training last year but indicated she did not remember what to do in those situations. On February 19, 2021, at 11:00 a.m. during a phone interview ULP-I stated she worked with ULP-A on the overnight shifts and ULP-A always yelled at C1 and would grab his arm and put her other arm behind his back and physically push him against his will down the hallway towards his room. ULP-I stated C1 would get upset and start to swing at ULP-A and ULP-A would yell at C1 to stop or she would punch him. ULP-I stated the verbal abuse and aggressive behavior with ULP-A and C1 happened every night she worked. ULP-I stated she considered ULP-A's verbally aggressive behavior abusive, but indicated she had never thought about reporting the ongoing verbal abuse. ULP-I stated if a client was being abused she would report it to her supervisor the next day when they were working. ULP-I indicated they had emergency on call staff available 24 hours a day, seven days a week. On February 23, 2021, at 9:20 a.m. during a phone interview with registered nurse clinical manager (RNCM)-F stated staff can call any time day or night to report allegations of abuse. RNCM-F stated she was called on October 31, 2021, at approximately 7:00 a.m. and told there was an altercation that occurred between ULP-A and C1. RNCM-F stated ULP-B had witnessed ULP-A hitting C1 and caused a skin tear on his arm. RNCM-F stated staff did not recognize the	02015		

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02015	Continued From page 45 incident between C1 and ULP-A were abusive. C3 was admitted to the facility on October 23, 2019, with diagnosis including Alzheimer's disease, chronic pain syndrome, impaired visual function, and major depressive disorder. C3's care plan dated October 23, 2019, indicated C3 was cognitively impaired and required staff assistance with ADL's including dressing, bathing, eating, personal hygiene, and transfers. C3 was visually impaired and staff were instructed to knock on the clients door prior to entering, address C3 by her name, and tell the client who you are and why you are there. C3's progress note dated June 5, 2020, at 11:19 a.m. indicated on May 4, 2020, at 5:45 a.m. while staff were rolling C3 in bed to provide incontinence cares, the client hit her head on the wall. The progress note indicated C3 had no bruising or visible injury. A hand written note by ULP-I dated May 4, 2020, indicated ULP-I was providing cares for C3. ULP-A came into C3's room to assist. ULP-A pushed the clients shoulders, "so hard and fast," the client hit her left forehead on the wall. ULP-A laughed after the C3's head hit the wall. ULP-I told ULP-A it was not funny and ULP-A replied laughing, "I am sorry but that was just so funny!" The facility Incident Report dated May 4, 2020, indicated two staff, ULP-I and ULP-A, were assisting C3 with personal hygiene cares in bed and turned C3 onto her side when the client accidentally bumped her head on the wall. The incident report lacked any of the initial internal information of the incident initially provided by ULP-I's hand written note regarding ULP-A's	02015		

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PIONEER HOME INC - CARE SUITES	1006 SOUTH SHERIDAN FERGUS FALLS, MN 56537

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02015	Continued From page 46 rough handling or laughing at C3. During interview on February 19, 2021, at 11:00 a.m. ULP-I stated she was providing personal hygiene cares to C3. Although ULP-I stated she didn't request assistance, ULP-A entered C3's room unannounced and abruptly shoved C3's upper body so hard and fast it caused the client to roll into the wall and hit her head. ULP-I stated when C3 hit her head on the wall ULP-A laughed at C3. ULP-I stated she told ULP-A it was not funny and it was mean, ULP-A responded, "I am sorry but that was just so funny." ULP-I stated she wrote a note regarding the incident and left it for administrative assistance (AA-G). During interview on February 24, 2021, at 8:55 a.m. AA-G stated ULP-I left her a note regarding the alleged incident of ULP-A turning C3 fast and hard, resulting in the client hitting her, and ULP-A laughing at the client. AA-G stated she had no documentation of an investigation being done; however, she stated she spoke to the staff involved and ULP-A denied the incident happened. AA-G stated there were only two staff involved and they both had different story's so a vulnerable adult report was not made to MAARC. During interview March 1, 2020, at 1:31 p.m. Registered Nurse Clinical Manager (RNCM)-F stated she reviewed the incident report regarding ULP-A and C3, but she was not aware ULP-I had initially reported the incident regarding C3 and ULP-A. RNCM-F stated she did not recall interviewing staff regarding the information on the incident report because C3 had no injury on her head, and she thought it was an issue with the clients bed being positioned against the wall. During interview on February 24, 2021, at 11:26	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20076	A. BUILDING: _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02015	Continued From page 47 a.m. Registered Nurse Housing Director (RNHD)-E stated she was responsible to review all incidents that occur in the facility. RNHD-E stated an internal investigation should be done to determine if maltreatment occurred, and based off those findings a report is made to MAARC. RNHD-E stated she recalled the incident on May 4, 2020, and indicated C3 accidentally bumped her head on the wall during cares. RNHD-E stated she had no knowledge of the allegation ULP-A treated C3 rough when she pushed her hard and fast causing her head to hit the wall and ULP-A laughed at the client. RNHD-E stated she though C3's bed was too close to the wall and needed to be moved. RNHD-E stated she would expect complete information to be included on the incident report, and the incident should be investigated and reported to MAARC. The facility policy titled Vulnerable Adult Reporting and Investigation, dated November 2014, indicated any staff who witnessed or suspected any form of maltreatment abuse must report the incident immediately to the registered nurse (RN) in charge or the housing director. The RN or Housing Director will complete an incident report. The facility policy titled Reporting Documenting and Reviewing Incidents Involving Residents, effective November 2014, indicated incident reports involving residents with be reviewed by the housing director. Staff would complete an incident report. Section 2. indicated if the incident must be reported to MAARC, the housing director or staff would do so as soon as possible but no later than 24 hours after the incident, and immediately begin an investigation. No additional information was provided.	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02015	Continued From page 48 Time Period for correction: Fourteen (14) days.	02015		