DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

REVISED TO REFLECT THE CORRECT COMPLAINT
PROJECT NUMBERS

Electronically delivered
January 24, 2019

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

RE: Project Number S5052029, H5052067, H5052068, H5052069, H5052075C, H50522076C
H5052073, H5052074C, H5052077C and H5052072

Dear Administrator:

On November 28, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 3, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedies and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 28, 2018.

In addition this Department is recommending to the CMS Region V Office that the following remedy be imposed:

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

This was based on the deficiencies cited by this Department for an extended survey completed on November 9, 2018 that included an investigation of complaint number H5052067, H5052068 and H5052069. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On January 4, 2019, the Minnesota Department of Health completed a Post Certification Revisit and on December 21, 2018, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on November 9, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on November 9, 2018. The

F0609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations
F0610 -- S/S: D -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation
F0684 -- S/S: D -- 483.25 -- Quality Of Care
F0812 -- S/S: F -- 483.60(i)(1)(2) -- Food Procurement,store/prepare/serve-Sanitary
F0880 -- S/S: E -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control

In addition, at the time of this revisit, we identified the following additional deficiencies:

F0607 -- S/S: D -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies
F0835 -- S/S: F -- 483.70 -- Administration

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

Also on January 4, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs, and to investigate complaint numbers H5052075C, H50522076C, and H5052077C that were found to be substantiated. The following complaint numbers were also investigated and were found unsubstantiated: H5052073, H5052074C, and H5052072. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 28, 2018 will remain in effect.

In addition this Department is recommending to the CMS Region V Office that the following remedy continued to be imposed:

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of November 28, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 9, 2018.

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 9, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD REHABILITATION & HEALTHCARE CENTER	**2810 SECOND AVENUE NORTH MOORHEAD, MN 56560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted on January 2, 3, 4 2019 to investigate complaints H5052073, H5052074C, H5052075C, H5052072, H5052076C, H5052077C. The complaints were found to be substantiated along with the related deficiency are as followings: H5052075C. Deficiency issued at F842 H5052076C. Deficiency issued at F607, F609, F610 H5052077C. Deficiency issued at F745 The following complaints were found to be unsubstantiated: H5052073, H5052074C, H5052072. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	F 607		2/6/19

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

Electronically Signed | 01/31/2019

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

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F 607	Continued From page 1 paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures to ensure the State Agency (SA) was immediately notified, no later than 2 hours following an allegation of physican/verbal abuse for 1 of 1 resident (R35) reviewed for allegations of abuse. In addition, the facility policy failed to provide clear guidelines for protection of the resident(s), during completion of a thorough investigation. Findings include: The facility policy titled Resident Protection Manual revised 8/2/18, directed procedures must be in place to provide the resident with a safe, protected environment until the investigation is completed. The policy indicated social services should keep in constant contact with the resident and/or representation, if the resident could be at risk in the same environment, evaluate the situation and consider some options including a room change or roommate change, if a family member is possibly contributing to the potential abuse and the resident could be at risk, evaluate the situation and consider some options including altered visitation. The policy further directed prior to the completion of the incident reporting process, the licensed nurse and staff will assure that the resident(s) involved are safe, removed from harm, protected from further incident and that their rights are protected. Further, the policy directed if alleged abuse occurs staff will: take immediate action to protect the individual(s) involved including removal of alleged abuser. However, the policy lacked clear guidelines for	F 607	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.The situation with the resident had occurred in the past and there were no more issues with the resident or that staff member. The staff member in question had education on the following topics on 1/25/19 “Transfers, pain management, sensitivity and bedside manner.” 2.All facility residents could be affected by this issue. Nursing staff Inservice on “Transfers, pain management, sensitivity and bedside manner” is scheduled for 2-6-19. This Inservice also will covered the revised “Resident Protection Manual” which has revised guidelines for resident protection. 3.The resident protection manual was reviewed and revised on 1-30-19 Facility administrator reviewed and revised “Resident Protection Manual” to include meeting federal guidelines for reporting, including language that outlines specifically protecting residents from further harm while investigating the incident, and reviewed with company COO and Regional Director of Clinical Services as well as with the facility management team to educate staff on	

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F 607	Continued From page 2 protection of all residents in the facility from potential abuse from the staff member while the investigation of the allegation of abuse was conducted. Review of the incident report submitted by the facility by the administrator on 12/31/18, at 12:51 p.m. revealed R35's family member (FM)-A had reported that NA-A was "rough" with R35 during a transfer, and indicated R35 said "Ow, ow, ow" during cares. FM-A had reported nursing assistant (NA)-A was rushed and "verbally abrasive" to R35. The report further indicated the facility's immediate action to protect the resident was NA-A was removed from R35's care. During an interview on 1/3/19, at 1:09 p.m. the administrator stated he had interviewed LPN-A, and NA-A for the initial intake, and stated he did not view the incident as abuse. The administrator stated it was "alleged abuse," and indicated he did not feel "willful abuse" had occurred. The administrator stated FM-A had reported NA-A was "rough" with care of R35, and FM-A felt NA-A was "verbally abrasive." The administrator stated NA-A was not aggressive but was "verbally abrasive" and told R35, "If you hurry up and help roll over it could get done sooner." The administrator indicated he felt he did not need to remove NA-A from contact with R35 or the other residents, because he did not feel it was abuse. The administrator stated LPN-A took immediate action to remove NA-A from providing care for R35 for the remainder of that shift. The administrator verified NA-A was removed from care for only R35 for that shift, and continued to provide care for other residents in the facility. On 1/3/19, at 4:30 p.m. during a follow up	F 607	components of the abuse program especially investigation of suspected maltreatment of a resident and the protection of that resident. The program further educates staff on when to report and what to report to ensure that this type of situation does not occur again. Proper procedure for incident and accidents and the notification process was reviewed with DON/SW and ED to ensure reporting of any situation which would require immediate follow up and reporting. Nursing, administration and SW were also educated on the policy and the regulation an on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints). Policy and procedure for reportable events was reviewed. All incidents, accidents, allegations of abuse or neglect and injuries of unknown origin will be logged to ensure follow up completed per resident protection manual and investigation log. 24 hour report will be monitored daily for 1 month to ensure allegations of abuse or neglect and injuries of unknown origin will be identified in a timely manner. The DON, ED in conjunction with SW will make report immediately if there is an injury of unknown origin or abuse/neglect or is suspected. Education on revised policy provided at all staff inservice on 2-6-19. 4.A quality-assurance program was implemented under the supervision of the SW to monitor all incidents to ensure that situations that include possible maltreatment of a resident follow the resident protection manual process	

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F 607	Continued From page 3 interview with the administrator, he stated the alleged "rough" handling of R35 could have been potential abuse. The administrator indicated after the initial staff interviews he had determined it was not "intentional harm," and no "willful abuse" had occurred, and stated it was "hurried care, not abuse." The administrator stated he felt R35 had been protected by removing NA-A from providing care for that shift, and indicated the facility had not put restrictions or monitoring of NA-A cares in place. The administrator stated no other interviews of staff or residents in the facility had occurred during his investigation of rough handling and abrasive language of R35. On 1/4/19, at 8:47 a.m. assistant director of nursing (ADON) stated the administrator was in the building at the time of the incident, and had interviewed LPN-A and NA-A within minutes of being notified of the abuse allegation. The ADON stated after the administrator interviewed those staff, he had concluded abuse did not occur. The ADON stated she felt NA-A would need retraining on safe patient handling and resident interactions. The ADON stated her understanding of the facility policy and what should occur in the event of an alleged abuse or neglect complaint/concern was the resident(s) safety is ensured by removing the alleged perpetrator from the immediate care of the resident(s), the alleged perpetrator would be sent home until further notice pending investigation, then an investigation is done. The ADON stated after completion of the investigation, if the allegation is unsubstantiated and it is determined the staff can return to work, retraining and education should be completed before the staff is allowed to provide any direct care for residents. The ADON verified that NA-A had not been removed from having access to	F 607	including specific actions to protect the resident. The SW or designee will complete daily audits for the next month on all reported Abuse, neglect and exploitation events to include measures for protection of resident and timeliness of reporting, then weekly for the next 2 months to help ensure the findings of the quality-assurance audits will be documented and submitted complete and timely. The results will be reviewed at the monthly quality-assurance committee meeting for further review or corrective action. 5.SW will be responsible for this POC.	

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F 607	Continued From page 4 R35 or the other residents in the building after the incident. ADON stated as of 1/4/19, NA-A had been reassigned to other resident groups, and was not aware NA-A provided direct care for R35.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 609	This Plan of Correction constitutes my	2/6/19

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F 609	Continued From page 5 facility failed to ensure an allegation of abuse was reported immediately, but no later than 2 hours, to the State Agency (SA) for 1 of 1 resident (R35) who was reviewed for allegations of rough handling during care. Findings include: R35's quarterly Minimum Data Set (MDS) assessment dated 10/10/18, identified R35 had moderate cognitive impairment and diagnoses which included arthritis, and pain. R35's annual Care Area Assessment (CAA) dated 10/16/18, indicated R35 was receiving hospice services, and had a cognitive decline recently likely due to end of life disease process, and further indicated R35 was vulnerable due to her cognitive loss. Additionally, the CAA indicated R35 had physical limitations and required extensive assistance from 1 staff and utilized a hoyer (full body lift device) for transfers. Review of the incident report submitted by the facility by the administrator on 12/31/18, at 12:51 p.m. revealed R35's family member (FM)-A had reported that NA-A was "rough" with R35 during a transfer, and indicated R35 said "Ow, ow, ow" during cares. FM-A had reported nursing assistant (NA)-A was rushed and "verbally abrasive" to R35. The report further indicated the facilities immediate action to protect the resident was NA-A was removed from R35's care. On 1/3/19, at 1216 a.m. during a telephone interview, FM-A stated they were visiting R35 on 12/30/18, around 4:00 p.m. when R35 requested to go to bed. FM-A indicated licensed practical nurse (LPN)-A entered the room and assisted	F 609	written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.The situation with the resident had occurred in the past and there were no more issues with the resident or that staff member. The staff member in question had education on the following topics on 1/25/19 “Transfers, pain management, sensitivity and bedside manner.” 2.All facility residents could be affected by this issue. Nursing staff Inservice on “Transfers, pain management, sensitivity and bedside manner” is scheduled for 2-6-19. This Inservice also will covered the revised “Resident Protection Manual” which has revised guidelines for resident protection. 3.The resident protection manual was reviewed and revised on 1-30-19 Facility administrator reviewed and revised “Resident Protection Manual” to include meeting federal guidelines for reporting, including language that outlines specifically protecting residents from further harm while investigating the incident, and reviewed with company COO and Regional Director of Clinical Services as well as with the facility management team to educate staff on components of the abuse program especially investigation of suspected maltreatment of a resident and the protection of that resident. The program	

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MOORHEAD REHABILITATION & HEALTHCARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

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F 609	Continued From page 6 R35 to transfer into bed with the hoyer. Then, NA-A entered the room, and LPN-A left the room. FM-A stated NA-A was assisting R35 to remove the sling, and grabbed R35's left shoulder and started to pull R35 over when R35 called out "Ow,ow,ow" in pain. FM-A stated NA-A did not stop to check on what was the causing R35 to call out in pain, or ask R35 what was wrong. FM-A stated NA-A was in a hurry and in an abrasive tone and told R35, "The sooner you roll over, the sooner we can get it out of here." FM-A stated she had observed the black square hard plastic hook from the sling that attached to the hoyer poking R35 in the back, and moved it out of the way so she could roll over it, and asked NA-A to leave. FM-A stated she saw no redness on R35's back after the sling was removed. FM-A stated after NA-A left R35's room, she immediately reported the incident to LPN-A, and requested NA-A not provide care for R35 anymore. During interview on 1/3/19, at 1:09 p.m. the administrator stated the incident was reported to him immediately on 12/30/18, at 4:25 p.m. The administrator stated he had interviewed LPN-A, and NA-A for the initial intake and stated he did not view the incident as abuse. The administrator stated it was alleged abuse, and indicated he did not feel willful abuse had occurred. The administrator stated FM-A had reported NA-A was "rough" with care of R35. The administrator verified R35's abuse allegation reporting was late and was not filed until the following afternoon. The administrator stated all allegations of abuse need to be reported within 2 hours, but explained he had issues with submitting the report on 12/30/18. The administrator verified he was responsible for submitting the reports, and stated	F 609	further educates staff on when to report and what to report to ensure that this type of situation does not occur again. Proper procedure for incident and accidents and the notification process was reviewed with DON/SW and ED to ensure reporting of any situation which would require immediate follow up and reporting. Nursing, administration and SW were also educated on the policy and the regulation an on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints). Policy and procedure for reportable events was reviewed. All incidents, accidents, allegations of abuse or neglect and injuries of unknown origin will be logged to ensure follow up completed per resident protection manual and investigation log. 24 hour report will be monitored daily for 1 month to ensure allegations of abuse or neglect and injuries of unknown origin will be identified in a timely manner. The DON, ED in conjunction with SW will make report immediately if there is an injury of unknown origin or abuse/neglect or is suspected. Education on revised policy provided at all staff inservice on 2-6-19. 4.A quality-assurance program was implemented under the supervision of the SW to monitor all incidents to ensure that situations that include possible maltreatment of a resident follow the resident protection manual process including specific actions to protect the resident. The SW or designee will complete daily audits for the next month on all reported Abuse, neglect and	

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	245052	A. BUILDING _____ B. WING _____	C 01/04/2019

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F 609	Continued From page 7 he would expect all reports to be completed within 2 hours. The administrator stated he did not feel the incident was abuse, and stated FM-A felt NA-A was rushed and was "verbally abrasive," and stated NA-A was not aggressive but was "verbally abrasive" when she told R35, "If you hurry up and help roll over it could get done sooner". On 1/3/19, at 3:15 p.m. NA-A stated she worked with R35 that day (1/3/19) and indicated she had just brought R35 to the dining room. NA-A stated she was aware of a complaint of rough handling, but was not aware of any restrictions from providing care to provide care for R35. NA-A stated LPN-A and FM-A had assisted R35 into bed with the hoyer. NA-A stated LPN-A left the room when she arrived, and FM-A remained in the room. NA-A stated when she rolled and tucked the sling behind R35 to remove the sling R35 said "ow ow". NA-A stated FM-A asked R35 what was wrong, started crying, and told NA-A to leave. R35 stated "I have never had a complaint on me before", and indicated she was trying to be careful and tuck the sheet when she rolled R35. NA-A stated LPN-A told her to stay away from R35, but indicated 2 times she had tried to go back to R35's room to apologize. A review of NA-A's employee record revealed she had started working in the facility in 2012. NA-A had received abuse/neglect training annually, with the most recent recorded date of 4-24-18. A facility document titled Golden Living Action Log indicated NA-A had been reported for resident abuse/neglect on 2/11/2015, the complaint was unsubstantiated and no disciplinary action was taken.	F 609	exploitation events to include measures for protection of resident and timeliness of reporting, then weekly for the next 2 months to help ensure the findings of the quality-assurance audits will be documented and submitted complete and timely. The results will be reviewed at the monthly quality-assurance committee meeting for further review or corrective action. 5.SW will be responsible for this POC.	

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F 609	Continued From page 8 On 1/3/19, at 4:30 p.m. during a follow up interview with the Administrator, he stated the alleged "rough" handling of R35 could have been potential abuse. The Administrator indicated after initial staff interviews he had determined it was not "intentional harm", and no "willful abuse" had occurred, and stated it was "hurried care, not abuse". On 1/4/19, at 8:47 a.m. assistant director of nursing (ADON) stated the administrator was in the building at the time of the incident and stated she would expect a report to be filed with the SA within 2 hours, then an investigation to be done. A review of the facility policy titled Resident Protection Manual revised 8/2/18, under the section titled "Reporting and Response" indicated allegations that involve abuse, neglect or mistreatment are reported immediately, but not later than 2 hours after the allegation is made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610		2/6/19

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F 610	Continued From page 9 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a thorough investigation of an allegation of potential abuse for 1 of 1 resident (R35) reviewed for abuse. In addition, the facility failed to protect residents in the facility after an allegation of abuse occurred for 1 of 1 resident (R35) who reported potential abuse. Findings include: R35's quarterly Minimum Data Set (MDS) assessment dated 10/10/18, identified R35 had moderate cognitive impairment and diagnoses which included Multiple Myeloma (a cancer of the blood), depression, arthritis, pain, and heart failure. R35's annual Care Area Assessment (CAA) dated 10/16/18, indicated R35 was receiving hospice services and had a cognitive decline recently likely due to end of life disease process, and further indicated R35 was vulnerable due to her cognitive loss. Additionally, the CAA indicated R35 had physical limitations and required extensive assistance from 1 staff and utilized a hoyer (full body lift device) for transfers. Review of the incident report submitted by the facility by the Administrator on 12/31/18, at 12:51 p.m. revealed R35's family member (FM)-A had reported that NA-A was "rough" with R35 during a transfer, and indicated R35 said "ow, ow, ow" during cares. FM-A had reported nursing	F 610	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.The situation with the resident had occurred in the past and there were no more issues with the resident or that staff member. The staff member in question had education on the following topics on 1/25/19 “Transfers, pain management, sensitivity and bedside manner.” 2.All facility residents could be affected by this issue. Nursing staff Inservice on “Transfers, pain management, sensitivity and bedside manner” is scheduled for 2-6-19. This Inservice also will covered the revised “Resident Protection Manual” which has revised guidelines for resident protection. 3.The resident protection manual was reviewed and revised on 1-30-19 Facility administrator reviewed and revised “Resident Protection Manual” to include meeting federal guidelines for reporting, including language that outlines specifically protecting residents from further harm while investigating the incident, and reviewed with company	

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F 610	Continued From page 10 assistant (NA)-A was rushed and "verbally abrasive" to R35. The report further indicated the facilities immediate action to protect the resident was NA-A was removed from R35's care. On 1/3/19, at 1216 a.m. during telephone interview, FM-A stated they were visiting R35 on 12/30/2018, around 4:00 p.m. when R35 requested to go to bed. FM-A indicated licensed practical nurse (LPN)-A entered the room and assisted R35 to transfer into bed with the hoyer. Then, NA-A entered the room, and LPN-A left the room. FM-A stated NA-A was assisting R35 to remove the sling, and grabbed R35's left shoulder and started to pull R35 over when R35 called out "ow,ow,ow" in pain. FM-A stated NA-A did not stop to check on what was the causing R35's to call out in pain, or ask R35 what was wrong. FM-A stated NA-A was in a hurry and in an abrasive tone and told R35 "the sooner you roll over, the sooner we can get it out of here". FM-A stated she had observed the black square hard plastic hook from the sling that attaches to the hoyer poking R35 in the back, and moved it out of the way so she could roll over it, and asked NA-A to leave. FM-A stated she saw no redness on R35's back after the sling was removed. FM-A stated after NA-A left R35's room, she immediately reported the incident to LPN-A, and requested NA-A not provide care for R35 anymore. During interview on 1/3/19, at 1:09 p.m. the Administrator stated the incident was reported to him immediately on 12/30/18, at 4:25 p.m. The Administrator stated he had interviewed LPN-A, and NA-A for the initial intake and stated he did not view the incident as abuse. The Administrator stated it was alleged abuse, and indicated he did	F 610	COO and Regional Director of Clinical Services as well as with the facility management team to educate staff on components of the abuse program especially investigation of suspected maltreatment of a resident and the protection of that resident. The program further educates staff on when to report and what to report to ensure that this type of situation does not occur again. Proper procedure for incident and accidents and the notification process was reviewed with DON/SW and ED to ensure reporting of any situation which would require immediate follow up and reporting. Nursing, administration and SW were also educated on the policy and the regulation an on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints). Policy and procedure for reportable events was reviewed. All incidents, accidents, allegations of abuse or neglect and injuries of unknown origin will be logged to ensure follow up completed per resident protection manual and investigation log. 24 hour report will be monitored daily for 1 month to ensure allegations of abuse or neglect and injuries of unknown origin will be identified in a timely manner. The DON, ED in conjunction with SW will make report immediately if there is an injury of unknown origin or abuse/neglect or is suspected. Education on revised policy provided at all staff inservice on 2-6-19. 4.A quality-assurance program was implemented under the supervision of the SW to monitor all incidents to ensure that	

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F 610	Continued From page 11 not feel willful abuse had occurred. The Administrator stated FM-A had reported NA-A was "rough" with care of R35. The Administrator stated LPN-A took immediate action to remove NA-A from providing care for R35 for the remainder of that shift, and indicated the facility planned to provide education and monitoring of NA-A's interactions and cares with other resident and staff in the facility. The Administrator indicated he felt he did not need to remove NA-A from contact with R35 or the other residents because he did not feel it was abuse, and stated hurried care was not abuse. The Administrator stated during the initial intake of the abuse allegation/complaint of rough handling of R35, he had determined no abuse had occurred. The Administrator verified NA-A was removed from care of R35 for that shift, and continued to provide care for other residents in the facility. On 1/3/19, at 3:15 p.m. during and interview NA-A stated she worked with R35 that day (1/3/19) and indicated she had just brought R35 to the dining room. NA-A stated she was aware of a complaint of rough handling, but was not aware of any restrictions from providing care to provide care for R35 or other residents. A review of NA-A's employee record revealed she had started working in the facility in 2012. NA-A had received abuse/neglect training annually, with the most recent recorded date of 4-24-18. An undated facility document titled Action Log indicated NA-A had been reported for resident abuse/neglect on 2/11/2015, the complaint had been unsubstantiated and indicated no disciplinary action had been taken. The log lacked any documentation of any further actions taken such as education or counseling.	F 610	situations that include possible maltreatment of a resident follow the resident protection manual process including specific actions to protect the resident. The SW or designee will complete daily audits for the next month on all reported Abuse, neglect and exploitation events to include measures for protection of resident and timeliness of reporting, then weekly for the next 2 months to help ensure the findings of the quality-assurance audits will be documented and submitted complete and timely. The results will be reviewed at the monthly quality-assurance committee meeting for further review or corrective action. 5.SW will be responsible for this POC.	

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F 610	Continued From page 12 On 1/3/19, at 4:30 p.m. during a follow up interview with the Administrator, he stated the alleged "rough" handling of R35 could have been potential abuse. The Administrator indicated after the two initial staff interviews he had determined it was not "intentional harm", and no "willful abuse" had occurred, and stated it was "hurried care, not abuse". The Administrator stated he felt R35 had been protected by removing NA-A from providing care for that shift, and indicated there had been no restrictions or monitoring of NA-A cares in the facility. The Administrator stated no other interviews of staff or residents in the facility had occurred during his investigation of rough handling and abrasive language of R35. On 1/4/19, at 8:47 a.m. assistant director of nursing (ADON) stated the Administrator was in the building at the time of the incident and had interviewed LPN-A and NA-A within minutes of being notified of the abuse allegation. The ADON stated after the Administrator interviewed the two staff, he had concluded abuse did not occur. The ADON stated she felt NA-A would need retraining on safe patient handling and resident interactions. The ADON verified NA-A had not been removed from having access to R35 or the other residents in the building after the incident, until the investigation was concluded. A review of the facility policy titled Moorhead Rehabilitation & Healthcare Center Resident Protection Manual revised 8/2/18, under the section titled "Reporting and Response" indicated allegations that involve abuse, neglect or mistreatment are reported immediately, but not later than 2 hours after the allegation is made. In addition, the section titled "Internal Facility	F 610		

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F 610	Continued From page 13 Investigation of Reports of Resident Maltreatment Investigation", section c. instructed the facility staff when a specific staff member is implicated in the alleged event, the person(s) will be removed from the resident care immediately, and suspended until the investigation is completed. Further, the facility provided policy titled "Report and Investigate - Accident/Incident Process and Reporting Policy and Procedure" revised 8/2/2018, instructed staff to take immediate action to protect the individual(s) involved including removal of the alleged abuser, but lacked clear definition for removal of the abuser while an investigation was being conducted.	F 610		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, and implement appropriate interventions for 1 of 1 resident (R152) who had a recurrent alcohol intoxication. Findings inlcude: Review of R152's quarterly Minimum Data Set (MDS) dated 11/8/18, identified R152 was cognitively intact, was sometimes understood (ability limited to making concrete requests) and had unclear speech. The MDS identified R152 had diagnoses which included cerebrovascular accident (CVA, also known as stroke), aphasia	F 745	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.Resident 152's care plan has been revised to include more interventions related to falls and safety. Fall risk assessment has been done for this resident. 2.No other residents were identified	2/6/19

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F 745	Continued From page 14 (impaired speech), hemiplegia (one sided paralysis), and alcohol dependence in remission. The MDS identified R152 had no behaviors, required extensive assistance with activities of daily living (ADLs) which included bed mobility, transfers, toileting, dressing, and personal hygiene. The MDS identified R152 did not walk, and was independent in locomotion with use of a wheelchair. The MDS revealed R152 was only able to stabilize himself with staff assistance when he moved from a seated to a standing position, moving on and off the toilet and with a surface to surface transfer. The MDS identified R152 had functional limited range of motion (ROM) impairment on one side of his upper and lower extremity. Further, the MDS identified R152 had two or more falls with no injury since the last assessment. Review of R152's annual Care Area Assessment (CAA) dated 3/8/18, identified R152 had aphasia, was unable to make himself understood verbally, and used gestures to make his needs known. The CAA identified R152 had left sided paralysis, and required extensive assistance from facility staff with ADLs which included transfers, bed mobility, toileting and personal hygiene. The CAA revealed R152 was at risk for falls and injury related to left sided paralysis, depression and use of an antidepressant. R152's CAA's lacked documentation of R152's alcohol use. R152's medical record lacked a fall risk assessment. Review of R152's facility incident reports revealed the following: - 4/28/18, at 12:00 a.m. R152 had a witnessed	F 745	regarding this deficiency, however Resident 94952 was also reviewed for safety issues related to Alcohol use. 3.Facility Alcohol and Drug Policy was updated on 2/6/18 to include language in regard to safety that addresses monitoring if they are identified to be intoxicated or under the influence. Staff were educated on this at all staff Inservice on 2/6/19. Social Work Policy has been updated by Social Worker and ED to be more specific to SW role regarding resident care plans and developing resident centered care plans with appropriate problem/goal/approaches. Discussed with IDT on 2/1/19 the importance of developing comprehensive Care Plans that address the resident's safety needs as well as reviewed the facility Drug and Alcohol policy. Care plans for residents who do actively use ETOH or other substances will be reviewed and updated by IDT. 4.A quality-assurance program was implemented under the supervision of the SW beginning on 2/6/19 to monitor care plans related to safety concerns including use of alcohol of residents to ensure the plan of care has current problem/goal/approaches to adequately address the resident's safety and are updated to reflect changes to the care plan as needed. The SW or designee will complete 2 audits per week for 2 months on care plans of those residents the IDT has identified specific safety concerns for. The results will be reviewed at the monthly quality-assurance committee meeting for further review or corrective	

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F 745	Continued From page 15 fall. R42 had turned his light on, requested to be transferred to his wheelchair and had "gestured" to smoke. The report revealed the author of the note had explained to R152 he had to wait an hour. The note revealed R152 had began shouting and had placed himself on the floor in an attempt to get to his wheelchair. The report revealed R152 was alert, oriented and had no injury. R152's incident report lacked a comprehensive analysis of the fall and any indication of fall prevention interventions. -6/10/18, at 12:21 p.m. R152 had an unwitnessed fall, had been found in the bathroom on his knees, and had a reddened knee. The incident report revealed R152 was alert and oriented. R152's incident report lacked any root cause analysis, comprehensive assessment, or fall interventions. -7/10/18, at 8:07 p.m. R152 had a unwitnessed fall, had been found outside against a pillar of the building. The incident report revealed R152 had been drinking alcohol, fell against the pillar, hit his head and fell into the bushes. The incident report revealed the author had taken away R152's "alcohol", R152 had become upset and "took off". The report revealed R152 had refused to return to the inside of the facility. The incident report revealed R152 had a gait imbalance and identified R152's drinking alcohol had been a factor in his unwitnessed fall. R152's incident report lacked any root cause analysis, comprehensive assessment, or fall interventions. Further the report lacked any monitoring of R152's alcohol consumption. - 8/21/18, at 6:30 a.m. R152 had an unwitnessed fall, had been found seated on the bathroom	F 745	action. 5.SW will be responsible for this POC.	

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F 745	Continued From page 16	F 745		

floor, a nursing assistant (NA) had reported R152 had slid to the floor with guided assistance. The incident report indicated R152 was non-verbal, had impaired memory and was drowsy. R152's incident report lacked any root cause analysis, comprehensive assessment, or fall interventions.

- 9/14/18, at approximately 7:00 p.m. R152 had an unwitnessed fall, he had been found by "passer-by's" on the ground outside of the building and had assisted him back into his wheelchair. R152's incident report revealed a staff member had assisted R152 back into the building, was alert, oriented and had "some alcohol odor", though had denied drinking. R152's incident report had a scratch on his left knee and back of his hand. The incident report revealed R152 was alert and oriented. Further, R152's incident report indicated he had been outside of the building on a LOA (leave of absence) when the incident had occurred and was unwitnessed by staff. R152's incident report lacked any root cause analysis, comprehensive assessment, or fall interventions.

-10/2/18, at 12:00 a.m. R152 had an unwitnessed fall, he had been found on the floor in the television room laying on his back and had shoes and socks on. R152's incident report revealed he was non-verbal and was unable to communicate what had lead to his fall. The incident report revealed R152 usually waited for staff to assist with transfers, was alert and oriented. R152's incident report indicated he had been educated to use the call light for transfers. R152's incident report lacked any root cause analysis, or comprehensive assessment.

-10/26/18, at 12:36 a.m. a facility nurse had found

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F 745	Continued From page 17 R152 drinking alcohol from a cup in another residents room. The incident report revealed the nurse took the cup away from R152, reminded him he could not drink alcohol in the facility. The incident report revealed R152 had punched the nurse, pulled at her clothes and had retrieved the cup of alcohol from the nurse. The incident report revealed the nurse had asked R152 if she should call the police, and indicated R152 had nodded. The report revealed the author of the report had notified the director of nursing (DON) and had been instructed to "write up a report" and she would review it when she arrived. R152's incident report revealed he was alert, oriented and had been aware of what he had been doing. The incident report revealed the local police department and R152's probation officer had been notified the following morning. Further, R152's incident report revealed R152 would be monitored per staff for further incidents and the local police would be notified if R152 was "caught" with alcohol. -11/3/18, at 10:19 p.m. R152 had an unwitnessed fall in his room, he had been found lying on the floor next to his bed, appeared to have slid out of bed and appeared drunk. The incident report revealed R152's belongings were searched for alcohol, none had been found. R152's incident report revealed he was confused, drowsy, had gait imbalance and had ambulated without assistance. R152's incident report revealed he appeared drunk, had wanted to use the bathroom, did not use the call light and had attempted to self transfer. Further, R152's incident report revealed staff were to monitor R152 for any issues with behavior, aggression, and presence of alcohol. R152's incident report lacked any root cause analysis, comprehensive	F 745		

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F 745	Continued From page 18 assessment, or fall/safety interventions -11/10/18, at 12:31 p.m. revealed R152 had struck and kicked a facility nursing assistant (NA) in the shower room. R152's incident report revealed an empty bottle of Vodka was found in his room and indicated intoxication could have been a contributing factor when R152 was drinking alcohol. The incident report lacked any intervention attempted or where in place to monitor R152's alcohol consumption and safety. Review of R152's care plan, revised 11/12/18, revealed R152's safety was at risk due to a barrier in communication, impaired cognitive function, physical limitations and could become physically aggressive. R152's care plan revealed he required physical assistance with ADL's and could make staff aware of his needs. The care plan revealed R152 had a behavior problem of drinking alcohol and at times was violent, due to alcohol dependency. R152's care plan directed facility staff to work with him "in pairs" if he was suspected of drinking due to physical aggression towards staff when drinking. R152's care plan directed facility staff to contact the police department if he had been drinking or had become violent with staff. Further, R152's care plan revealed he was at moderate risk for falls and staff were to monitor R152 to ensure he was not consuming alcohol. Review of R152's progress notes from 4/28/18, to 1/4/19, revealed the following: -5/2/18, revealed a fall risk and mobility review which indicated R152 had falls in the last 30 days and in the last two to six months. The note revealed the following could increase R152's fall	F 745		

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risk; diagnoses of seizure disorder, hemiplegia, diabetes, occasional incontinence, limited range of motion and need for assistance with ADL's.

-5/25/18, at 11:56 p.m. R152 had signed himself out of the facility at 3:00 p.m., and the facility had received a phone call indicating R152 was found by police at a bus stop in Fargo, North Dakota, and had been unable to communicate with the police, and they had placed R152 back on the bus to the facility. The note revealed R152 had returned to the facility at 7:45 p.m. R152's progress note lacked indication of R152's condition upon return.

- 6/13/18, revealed R152's primary medical doctor (MD)-B had ordered occupational therapy to evaluate R152 and treat.

- 6/15/18, R152 had returned to the facility at 7:30 p.m. with slurred speech, inability to hold his head up and had appeared intoxicated. The note revealed R152 had been assisted to bed, and hourly checks had been initiated. The note revealed R152 had attempted to get out of his bed independently at 9:00 p.m. and had been reminded to stay in bed. Further, the note revealed another resident had informed staff R152 had drank an entire bottle of whiskey, the director of nursing was notified.

-7/4/18, at 9:11 p.m. R152 had been drinking alcohol and had fallen outside of the building. The note revealed R152 had been assisted off of the ground, refused to re-enter the facility and left facility grounds.

- 7/5/18, facility staff had notified local non-emergency law enforcement at 12:35 a.m.

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R152 had left the facility grounds without "signing himself out." A further note revealed the facility received a call from police at 12:59 a.m. indicated they had located R152, he had refused to enter the polices car. The note revealed R152's sister had been notified and had picked up R152 with a facility staff member's assistance. The note further indicated staff were expecting his arrival. R152's medical record lacked any documentation of R152's return to the facility.

-7/18/18, R152 had smelled of alcohol and had denied drinking.

-7/29/18, R152 had been found outside drinking with another resident, staff confiscated the bottle of alcohol and R152 had become combative. The note revealed R152 had calmed and allowed staff to assist him back into the facility. The note indicated staff notified the assistant director of nursing (ADON) of the situation.

-8/21/18, at 1:45 a.m. R152 had been drinking alcohol with three other residents outside of the building in the smoking area at 11:35 p.m. the night before. The note revealed facility staff had confiscated a bottle of vodka and indicated R152 was "too drunk to respond" to staff, was assisted into the facility via wheelchair, to his room. The note revealed R152 had drooled all over himself and was unable to respond to staff. The note revealed the ADON was notified. A later note revealed at 7:19 a.m. R152 had been assisted to the ground by a nursing assistant (NA) as R152 had slid towards the ground.

-9/6/18, at 11:08 p.m. R152 had returned to his room from the outside, appeared intoxicated and indicated to facility staff he was intoxicated. The

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note revealed staff were unable to locate any alcohol in R152's room, he was assisted to bed and encouraged to use his call light for assistance. Further, the note revealed the facility's DON had been notified.

-9/7/18, R152 had been outside and was suspected of drinking alcohol, staff requested to smell his bottle of Gatorade. The note revealed R152 had refused and left the facility grounds in his wheelchair. The note revealed R152's sister had been notified, facility administrator and the DON. R152's progress notes did not indicate when R152 returned to the facility, or his condition.

-9/14/18, "Passer-by's" had found R152 on the ground outside the facility, and had assisted R152 back into his wheelchair. The note revealed R152 was assisted back into the building by facility staff. The note revealed R152 had a scratch on his left knee and back of his right hand.

- 9/18/18, R152 had a heavy smell of alcohol on his breath, though was not observed drinking. The note revealed R152 would be monitored that night.

-9/18/18, revealed R152's probation officer had been notified of R152's drinking in the facility, and the note indicated R152's probation officer would speak with the supervisor and call the facility back.

- 9/21/18, R152's probation officer had come to the facility, met with R152 and facility administration. The note revealed shortly after R152 had met with his probation officer, he had left the facility without signing out and was

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observed to wheel himself to the liquor store. The note revealed the facility social worker had met R152 inside the liquor store where he had a bottle of vodka. The note revealed the facility social worker followed R152 back to the facility and reminded him not to consume alcohol or go to the liquor store. The note revealed R152 nodded in agreement.

-9/24/18, R152's probation officer and supervisor had met with R152 and the facility social worker to discuss R152's drinking alcohol. The note revealed a bottle of vodka had been found in R152's top drawer to his nightstand. The note further revealed R152's probation officer had advised the facility to notify them if R152 continued to drink, and informed them they possibly could revoke R152's probation.

- 9/28/18, R152 had been observed to be at a liquor store near the facility, and upon return R152's room fridge was checked, a fifth of vodka was found with 1/3 missing from the bottle. The note revealed the facility DON had been notified and advised to pour the remaining vodka down the sink, and to monitor R152 for the night.

-10/1/18, R152's probation officer had been updated regarding R152's drinking alcohol.

- 10/3/18, an activity care conference note which revealed a concern for R152's drinking issues.

-10/3/18, R152 had met with facilty social worker and probation officer in the facility. The note revealed R152 had been notified if he continued drinking alcohol he would be arrested and returned to jail in North Dakota. A further note revealed R152's probation officer instructed

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facility staff to notify the local police department if R152 was drinking and the police would contact R152's probation officer.

-10/26/18, R152 had been drinking, and had a violent altercation with a facility staff member.

-11/3/18, R152 had been found on the floor of his room and had slipped out of bed. The note revealed R152 had appeared drunk and had been trying to self transfer. The note revealed neurological checks could not be completed due to R152's intoxication.

-11/4/18, R152 had been shouting at staff, and had insisted he wanted to get up in his wheelchair and go outside to smoke. The note revealed R152 had appeared drunk and staff had encouraged him to stay in bed.

-11/10/18, R152 had struck an NA in the shower room and local police had been notified. A later note revealed law enforcement had instructed staff to work with R152 in pairs.

- 11/19/18, R152 had smoked marijuana. The note revealed R152's probation officer was notified, and had indicated they had would give R152 30 days to complete a chemical use assessment.

-12/3/18, a provider progress note had been received and indicated R152 had alcohol abuse disorder, worsening and had a detailed discussion with social worker to abstain from alcohol.

-12/11/18, facility social worker had been notified R152 smelled of alcohol and a bottle of vodka

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had been found in the bottom of the drawer of his dresser. The note revealed R152's probation officer arrived to the facility, and R152's breathalyzer was 0.035. The note indicated R152's probation officer had notified the local police department, who would not take R152 to jail due to medical conditions, and the county jail nurse had left for the day. The note revealed R152 had been reminded he needed to complete a chemical assessment within 30 days, however R152 acknowleged he would not be completing a chemical dependency assessment, and preferred to go to jail.

-12/15/18, R152 was inebriated, and a soda bottle with alcohol in it had been removed from his room. R152 had been slurring his words. The note revealed the facility contacted local police, a breathalyzer test was given in which R152 had blown a 0.175. The note revealed officers recorded the information and left the facility.

-1/2/19, R152 had met with his North Dakota probation officer, and his probation had been lifted. The note revealed at that time R152's Minnesota probation had also been lifted. The note revealed the facility administrator had notified R152's family member his probation had been lifted, and further informed R152's family member "that for now, R152 was still a resident."

-1/4/19, revealed the facility had been updated R152 was no longer on probation, and at that time the facility would monitor for periods of intoxication.

On 1/3/19, at 2:07 p.m. NA-B stated R152 required extensive assistance with ADL's with assistance of two staff members. She indicated

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she routinely worked with R152. NA-B stated R152 was able to let staff know of his needs, and he requested when he needed cares completed. She indicated there were times R152 would sleep most of the day, until approximately 2:00 p.m. on most days. NA-B indicated R152 was able to come and go from the facility once he was assisted into his wheelchair. She stated she had been informed by other facility staff R152 had been drinking alcohol in and out of the building, though indicated she had not observed R152 drinking alcohol. She stated she felt he drank in the evenings and night shifts and stated she felt he slept into the afternoon due to this. NA-B indicated she was unaware of any monitoring in place for R152's drinking alcohol.

On 1/3/19, at 4:46 p.m. NA-C stated R152 required extensive assistance with all cares, and indicated he routinely worked with R152. NA-C stated R152 had a history of falls, though indicated he had not fallen recently. NA-C stated R152 had been intoxicated from alcohol multiple times within the last few months, and stated he had smelled alcohol on R152's breath. He stated he had let the nurse know, and indicated he was unaware of any changes in R152's plan of care since then. NA-C stated R152 was not on routine checks or monitoring for any behaviors of drinking alcohol.

On 1/3/19, at 4:51 p.m. trained medication aide (TMA)-D stated R152 had a history of falls which usually occurred when R152 had been drinking. TMA-D stated R152 was not supposed to drink alcohol in the facility, and his probation officer had come out to the facility within the past few months. She stated R152 was recently released from probation, and was unaware of any

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monitoring in place for R152's alcohol consumption, or suspicion of. TMA-D stated R152 would often become aggressive when he was intoxicated, and indicated when R152 was sober he was cooperative and pleasant. She indicated she felt R152's face would often become red when he was intoxicated, but had shown no other signs other than aggression. TMA-D stated she would contact R152's MD to notify her of any suspicion of intoxication, and would follow up on holding R152's medications if needed.

On 1/3/19, at 4:58 p.m. the assistant director of nursing (ADON) stated she had been aware R152 had been drinking alcohol in the facility and had become intoxicated. She indicated R152 often became aggressive when he drank, would sway, and his face would get red. The ADON stated she felt R152's could not transfer safely when he had been drinking, was more prone to self transfers and impulsive behavior. The ADON stated R152's probation officer and police were notified of R152's alcohol consumption and indicated no action had been taken by either parties. The ADON confirmed there were no current interventions or monitoring in place by the facility for R152's alcohol consumption. She further confirmed R152's fall incident reports lacked comprehensive assessment, root cause analysis, monitoring and/or any intervention to provide safety interventions when R152 consumed alcohol.

On 1/3/19, at 1:48 p.m. R152 was seated in his wheelchair near the front entrance by the nurse's station. R152 conversed with another male resident and a female resident. R152 propelled himself towards the front door with the other two

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residents. R152 propelled himself outside to the facility's resident smoking area.

On 1/3/19, at 5:12 p.m. R152 was seated in his wheelchair by the nurse's station. He was dressed in a coat, stocking cap and tennis shoes. R152 propelled himself from the entryway down the hall towards his bedroom.

On 1/4/19, at 8:38 a.m. R152 was seated in his wheelchair, propelled himself down the hallway towards the front entrance of the facility. R152 was dressed in a coat, stocking cap and tennis shoes. R152 had an unlit cigarette in his right hand.

On 1/3/19, at 5:17 p.m. TMA-B stated R152 had fallen within the past few months and indicated R152 had consumed alcohol within the last few months. TMA-B stated R152 had drank alcohol as recently as a few weeks ago. She indicated she felt R152 became aggressive when he drank, but felt she had a hard time noticing any other way. TMA-B stated R152 would be actively drink at night, and was unsure of when he would actually drink the alcohol. TMA-B stated she had notified the registered nurse at the times R152 had appeared drunk. She indicated she was unaware of any monitoring in place for R152's consumption of alcohol.

On 1/3/18, at 5:23 p.m. licensed practical nurse (LPN)-A stated R152 was often very red in the face in the mornings, and stated she felt R152 drank daily and would not show outward signs of drinking until he became aggressive. LPN-A indicated she had searched his room routinely and outside in the facility smoking area, she had found a bottle of liquor in the bench where the fire

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blanket was kept. LPN-A stated there was no current monitoring in place for R152's consumption of alcohol and/or safety.

On 1/3/19, at 5:38 p.m. TMA-C stated she had worked with R152 for approximately the last seven months, and indicated she was unaware if R152 had consumed alcohol at any time in the last seven months. TMA-C stated she was not aware of any safety interventions in place for R152.

On 1/4/19, at 7:55 a.m. the facility administrator stated he had been aware of R152's continued alcohol consumption, and had met with the IDT team. He confirmed at the time of the survey, R152 had declined a chemical dependency assessment, and was unaware of any interventions in place to monitor R152's alcohol consumption and safety. The administrator stated the facility's social service director had resigned as of 12/24/18, and stated he was unaware of any other interventions or other measures taken to monitor and ensure the safety of R152 when he consumed alcohol.

On 1/4/19, at 9:00 a.m. the Regional Director of Clinical Services (RDCS) confirmed R152 was not currently monitored for alcohol intoxication or for safety. She stated R152 last drank a few weeks ago, and indicated she felt R152 drank very little and would get very happy when he drank. The RDCS stated she felt R152 was not aggressive when he drank, and would try to interact with staff more so when he was intoxicated. The RDCS indicated she had discussed R152's case with the DON at a sister facility as the facility "deals with residents" with chemical dependency. She indicated she did not

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MOORHEAD REHABILITATION & HEALTHCARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 29	F 745		

feel R152's alcohol consumption and intoxication increased his risk for falls, and felt other residents may have enticed R152 to drink. The RDCS indicated she felt R152's impulse control and safety awareness were affected by R152's alcohol consumption and intoxication. RDCS confirmed previous care plan did not given direction for his alcohol consumption.

On 1/4/19, at 1:03 p.m. R152's physician (MD)-B returned a telephone call and left a message for a return call. At 3:12 p.m. a telephone interview was conducted with MD-B. MD-B confirmed she was R152's primary physician and had not recently been in the facility to see him. MD-B stated she had recommended R152 be sent to a rehab center for his alcohol consumption in the past. MD-B stated she felt R152's drinking had worsened, and indicated he would become very aggressive when drinking. She indicated she was not aware if R152 had refused treatment and stated if he had, she would expect the facility to implement strong monitoring to ensure R152's safety. MD-B stated she had overall concerns with the management, administration, and nursing staff of the facility. She indicated she had concerns with the facility's ability to care for the residents and indicated the staff would often not follow through with her orders and or direction. MD-B stated she felt the residents within the facility were at risk and feared for their safety.

A facility policy titled Alcohol and Drug Policy, created 9/21/18, directed it was the policy of the facility to provide care to residents who required chronic disease management. The policy directed it was the facility's responsibility to ensure the safety of residents, and if drugs or alcohol had been determined to compromise safety, the

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F 745	Continued From page 30 facility would implement approaches to address the safety concerns. The policy indicated the use and possession of illegal drugs or alcohol were strictly prohibited. The policy revealed the facility would allow a controlled amount of alcohol to be consumed by residents under the direction of the provider. The policy listed various interventions and approaches to be provided to the resident if alcohol or drug consumption was identified; assessing triggers, warning systems, counseling, managed risk, chemical dependency or detox referral, sending resident to the emergency room if there behavior puts themselves, other residents or staff at risk, additional staff training and considering discharge with a safe discharge plan.	F 745		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		2/6/19

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F 842	Continued From page 31 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 32 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure accurate medical records for 1 of 1 residents (R152) reviewed for accident hazards and alcohol intoxication. Findings include: Review of R152's quarterly Minimum Data Set (MDS) dated 11/8/18, identified R152 was cognitively intact, was sometimes understood (ability limited to making concrete requests) and had unclear speech. The MDS identified R152 had diagnoses which included cerebrovascular accident (CVA, also known as a stroke), aphasia (impaired speech), hemiplegia (one sided paralysis), and alcohol dependence in remission. The MDS identified R152 had no behaviors, required extensive assistance with activities of daily living (ADLs) which included bed mobility, transfers, toileting, dressing and personal hygiene. The MDS identified R152 did not walk, and was independent in locomotion with use of a wheelchair. The MDS revealed R152 was only able to stabilize himself with staff assistance when he moved from a seated to a standing position, moving on and off the toilet, and with a surface to surface transfer. The MDS identified R152 had functional limited range of motion (ROM) impairment on one side of his upper and lower extremity. Further, the MDS identified R152 had two or more falls with no injury since the last	F 842	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to keep medical records with sufficient information to identify the resident; A record of the resident's assessments; The comprehensive plan of care and services provided. Some of the many ways that this has been for R152 is full review of assessments and care plan needs related to risk for falls and changes in services. After the surveyor noted many falls related to intoxication it became apparent the follow up was not adequate to ensure staff were monitoring effectively. The care plan was updated while surveyor present and was aware due to correction being made that day not prior and was due to a change in probation status within previous 24 hours as determined appropriate to update per care plan guidelines. No other interventions were added only the probation status discontinued. The medical records policy has been reviewed and revised regarding the altering of the	

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F 842	Continued From page 33 assessment. Review of R152's care plan, revised 11/12/18, revealed R152's safety was at risk due to a barrier in communication, impaired cognitive function, physical limitations, and could become physically aggressive. R152's care plan revealed he required physical assistance with ADLs and could make staff aware of his needs. The care plan revealed R152 had a behavior problem of drinking alcohol and at times was violent, due to alcohol dependency. R152's care plan directed facility staff to work with him "in pairs" if he was suspected of drinking due to physical aggression towards staff when drinking. R152's care plan directed facility staff to contact the police department if he had been drinking or had become violent with staff. R152's care plan directed facility staff to contact his probation officer when suspected of drinking alcohol. Further, R152's care plan revealed he was at moderate risk for falls and staff were to monitor R152 to ensure he was not consuming alcohol. On 1/3/19, at 4:58 p.m. the assistant director of nursing (ADON) stated R152's probation officer and police were notified of R152's alcohol consumption, and indicated no action had been taken by either parties. The ADON confirmed there were no current interventions or monitoring in place by the facility for R152's alcohol consumption. She further confirmed R152 had recently been discharged from probation. On 1/3/19, at 5:35 p.m. a request was made for a copy of R152's care plan to the facility's interim director of nursing (DON). At that time, the DON went to an office to a computer and pulled up R152's care plan on the electronic medical record	F 842	medical record. 2.Because all residents are at risk for falls and have a medical record all are potentially affected by the cited deficiency. All care plans have been audited to ensure they are accurate, and no alterations were made in this review; only updates as allowed by guidelines of NCSBN are followed. Falls have been reviewed for interventions and assessments have been updated. This care plan was updated to alert staff when resident gets money from business office to indicate could potentially buy liquor, staff know when R152 makes chest thump motion and is bit more flushed likely been drinking so keep in common area to be monitored. Weekly room checks will be completed. Will continue working with options for chemical dependency. No other residents were determined to be at risk. 3.To enhance currently compliant operations and under the direction of the director of nursing on 1/29/2019, all staff will be in-serviced on falls, interventions and resident specific interventions to prevent falls. 4.Effective 1/30/2019, a quality-assurance program was implemented under the supervision of the director of SW and ED to monitor safety and interventions of this resident. The director of SW or designated quality-assurance representative will perform the following systematic changes: Care plans changes will be reviewed at IDT Monday – Friday for timeliness, appropriateness of change, end if entered into the document as a	

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F 842	Continued From page 34 of Point Click Care. At that time, the regional director of clinical services (RDCS) entered the interim DON's office, stood in front of the computer, blocking surveyors sight, and asked the interim DON to change R152's care plan. The RDCS suggested to the surveyor to use the restroom. The RDCS stated she had the interim DON remove an intervention on R152's care plan, of contacting R152's probation office in the event of alcohol consumption. Surveyor requested a copy of R152's care plan prior to RDCS request for alteration. On 1/4/19, at 7:30 a.m. the DON stated the RDCS had directed her to change R152's care plan in order to add staff to monitor for alcohol consumption on 1/3/19, and further had instructed her to remove notifying R152's probation officer from the care plan interventions. On 1/4/19, at 7:55 a.m. the facility administrator stated he had been aware of R152's continued alcohol consumption, and had met with the IDT team. The administrator was informed of the DON's alteration of R152's care plan at the direction of the RDCS. He indicated he had been unaware of any instances of the RDCS falsifying or altering resident medical records in the past or currently. He indicated he would expect resident medical records to be accurate and reliable. On 1/4/19, at 9:00 a.m. the RDCS confirmed she had the DON add monitoring to R152's care plan, and remove R152's probation from his care plan. The RDCS confirmed R152 was not currently monitored for alcohol intoxication or for safety. The RDCS confirmed previous care plan did not given direction for his alcohol consumption.	F 842	legal part of the record. Audits will be completed 3x/week for 2 weeks, then weekly for 2 months and monthly for one month to ensure compliance. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly QAPI meeting for further review or corrective action. 5.SW and ED will be responsible for this corrective action	

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F 842	Continued From page 35 A facility policy titled Medical Records Safeguarding, revised 1/4/19 (while surveyors were onsite), revealed all records would be reviewed prior to giving to any entity.	F 842		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 2, 3, 4th, 2019, surveyors of this Department's staff visited the above provider for a complaint investigation and the following correction orders were issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, and implement appropriate interventions for 1 of 1 resident (R152) who had a recurrent alcohol intoxication. Findings inlcude: Review of R152's quarterly Minimum Data Set (MDS) dated 11/8/18, identified R152 was cognitively intact, was sometimes understood (ability limited to making concrete requests) and had unclear speech. The MDS identified R152 had diagnoses which included cerebrovascular accident (CVA, also known as stroke), aphasia (impaired speech), hemiplegia (one sided paralysis), and alcohol dependence in remission.	21475	corrected	2/1/19

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The MDS identified R152 had no behaviors, required extensive assistance with activities of daily living (ADLs) which included bed mobility, transfers, toileting, dressing, and personal hygiene. The MDS identified R152 did not walk, and was independent in locomotion with use of a wheelchair. The MDS revealed R152 was only able to stabilize himself with staff assistance when he moved from a seated to a standing position, moving on and off the toilet and with a surface to surface transfer. The MDS identified R152 had functional limited range of motion (ROM) impairment on one side of his upper and lower extremity. Further, the MDS identified R152 had two or more falls with no injury since the last assessment.

Review of R152's annual Care Area Assessment (CAA) dated 3/8/18, identified R152 had aphasia, was unable to make himself understood verbally, and used gestures to make his needs known. The CAA identified R152 had left sided paralysis, and required extensive assistance from facility staff with ADLs which included transfers, bed mobility, toileting and personal hygiene. The CAA revealed R152 was at risk for falls and injury related to left sided paralysis, depression and use of an antidepressant. R152's CAA's lacked documentation of R152's alcohol use.

R152's medical record lacked a fall risk assessment.

Review of R152's facility incident reports revealed the following:

- 4/28/18, at 12:00 a.m. R152 had a witnessed fall. R42 had turned his light on, requested to be transferred to his wheelchair and had "gestured" to smoke. The report revealed the author of the

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note had explained to R152 he had to wait an hour. The note revealed R152 had began shouting and had placed himself on the floor in an attempt to get to his wheelchair. The report revealed R152 was alert, oriented and had no injury. R152's incident report lacked a comprehensive analysis of the fall and any indication of fall prevention interventions.

-6/10/18, at 12:21 p.m. R152 had an unwitnessed fall, had been found in the bathroom on his knees, and had a reddened knee. The incident report revealed R152 was alert and oriented. R152's incident report lacked any root cause analysis, comprehensive assessment, or fall interventions.

-7/10/18, at 8:07 p.m. R152 had a unwitnessed fall, had been found outside against a pillar of the building. The incident report revealed R152 had been drinking alcohol, fell against the pillar, hit his head and fell into the bushes. The incident report revealed the author had taken away R152's "alcohol", R152 had become upset and "took off". The report revealed R152 had refused to return to the inside of the facility. The incident report revealed R152 had a gait imbalance and identified R152's drinking alcohol had been a factor in his unwitnessed fall. R152's incident report lacked any root cause analysis, comprehensive assessment, or fall interventions. Further the report lacked any monitoring of R152's alcohol consumption.

- 8/21/18, at 6:30 a.m. R152 had an unwitnessed fall, had been found seated on the bathroom floor, a nursing assistant (NA) had reported R152 had slid to the floor with guided assistance. The incident report indicated R152 was non-verbal, had impaired memory and was drowsy. R152's

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incident report lacked any root cause analysis, comprehensive assessment, or fall interventions.

- 9/14/18, at approximately 7:00 p.m. R152 had an unwitnessed fall, he had been found by "passer-by's" on the ground outside of the building and had assisted him back into his wheelchair. R152's incident report revealed a staff member had assisted R152 back into the building, was alert, oriented and had "some alcohol odor", though had denied drinking. R152's incident report had a scratch on his left knee and back of his hand. The incident report revealed R152 was alert and oriented. Further, R152's incident report indicated he had been outside of the building on a LOA (leave of absence) when the incident had occurred and was unwitnessed by staff. R152's incident report lacked any root cause analysis, comprehensive assessment, or fall interventions.

-10/2/18, at 12:00 a.m. R152 had an unwitnessed fall, he had been found on the floor in the television room laying on his back and had shoes and socks on. R152's incident report revealed he was non-verbal and was unable to communicate what had lead to his fall. The incident report revealed R152 usually waited for staff to assist with transfers, was alert and oriented. R152's incident report indicated he had been educated to use the call light for transfers. R152's incident report lacked any root cause analysis, or comprehensive assessment.

-10/26/18, at 12:36 a.m. a facility nurse had found R152 drinking alcohol from a cup in another residents room. The incident report revealed the nurse took the cup away from R152, reminded him he could not drink alcohol in the facility. The incident report revealed R152 had punched the

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nurse, pulled at her clothes and had retrieved the cup of alcohol from the nurse. The incident report revealed the nurse had asked R152 if she should call the police, and indicated R152 had nodded. The report revealed the author of the report had notified the director of nursing (DON) and had been instructed to "write up a report" and she would review it when she arrived. R152's incident report revealed he was alert, oriented and had been aware of what he had been doing. The incident report revealed the local police department and R152's probation officer had been notified the following morning. Further, R152's incident report revealed R152 would be monitored per staff for further incidents and the local police would be notified if R152 was "caught" with alcohol.

-11/3/18, at 10:19 p.m. R152 had an unwitnessed fall in his room, he had been found lying on the floor next to his bed, appeared to have slid out of bed and appeared drunk. The incident report revealed R152's belongings were searched for alcohol, none had been found. R152's incident report revealed he was confused, drowsy, had gait imbalance and had ambulated without assistance. R152's incident report revealed he appeared drunk, had wanted to use the bathroom, did not use the call light and had attempted to self transfer. Further, R152's incident report revealed staff were to monitor R152 for any issues with behavior, aggression, and presence of alcohol. R152's incident report lacked any root cause analysis, comprehensive assessment, or fall/safety interventions

-11/10/18, at 12:31 p.m. revealed R152 had struck and kicked a facility nursing assistant (NA) in the shower room. R152's incident report revealed an empty bottle of Vodka was found in

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his room and indicated intoxication could have been a contributing factor when R152 was drinking alcohol. The incident report lacked any intervention attempted or where in place to monitor R152's alcohol consumption and safety.

Review of R152's care plan, revised 11/12/18, revealed R152's safety was at risk due to a barrier in communication, impaired cognitive function, physical limitations and could become physically aggressive. R152's care plan revealed he required physical assistance with ADL's and could make staff aware of his needs. The care plan revealed R152 had a behavior problem of drinking alcohol and at times was violent, due to alcohol dependency. R152's care plan directed facility staff to work with him "in pairs" if he was suspected of drinking due to physical aggression towards staff when drinking. R152's care plan directed facility staff to contact the police department if he had been drinking or had become violent with staff. Further, R152's care plan revealed he was at moderate risk for falls and staff were to monitor R152 to ensure he was not consuming alcohol.

Review of R152's progress notes from 4/28/18, to 1/4/19, revealed the following:

-5/2/18, revealed a fall risk and mobility review which indicated R152 had falls in the last 30 days and in the last two to six months. The note revealed the following could increase R152's fall risk; diagnoses of seizure disorder, hemiplegia, diabetes, occasional incontinence, limited range of motion and need for assistance with ADL's.

-5/25/18, at 11:56 p.m. R152 had signed himself out of the facility at 3:00 p.m., and the facility had received a phone call indicating R152 was found

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by police at a bus stop in Fargo, North Dakota, and had been unable to communicate with the police, and they had placed R152 back on the bus to the facility. The note revealed R152 had returned to the facility at 7:45 p.m. R152's progress note lacked indication of R152's condition upon return.

- 6/13/18, revealed R152's primary medical doctor (MD)-B had ordered occupational therapy to evaluate R152 and treat.

- 6/15/18, R152 had returned to the facility at 7:30 p.m. with slurred speech, inability to hold his head up and had appeared intoxicated. The note revealed R152 had been assisted to bed, and hourly checks had been initiated. The note revealed R152 had attempted to get out of his bed independently at 9:00 p.m. and had been reminded to stay in bed. Further, the note revealed another resident had informed staff R152 had drank an entire bottle of whiskey, the director of nursing was notified.

-7/4/18, at 9:11 p.m. R152 had been drinking alcohol and had fallen outside of the building. The note revealed R152 had been assisted off of the ground, refused to re-enter the facility and left facility grounds.

- 7/5/18, facility staff had notified local non-emergency law enforcement at 12:35 a.m. R152 had left the facility grounds without "signing himself out." A further note revealed the facility received a call from police at 12:59 a.m. indicated they had located R152, he had refused to enter the polices car. The note revealed R152's sister had been notified and had picked up R152 with a facility staff member's assistance. The note further indicated staff were expecting his arrival.

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R152's medical record lacked any documentation of R152's return to the facility.

-7/18/18, R152 had smelled of alcohol and had denied drinking.

-7/29/18, R152 had been found outside drinking with another resident, staff confiscated the bottle of alcohol and R152 had become combative. The note revealed R152 had calmed and allowed staff to assist him back into the facility. The note indicated staff notified the assistant director of nursing (ADON) of the situation.

-8/21/18, at 1:45 a.m. R152 had been drinking alcohol with three other residents outside of the building in the smoking area at 11:35 p.m. the night before. The note revealed facility staff had confiscated a bottle of vodka and indicated R152 was "too drunk to respond" to staff, was assisted into the facility via wheelchair, to his room. The note revealed R152 had drooled all over himself and was unable to respond to staff. The note revealed the ADON was notified. A later note revealed at 7:19 a.m. R152 had been assisted to the ground by a nursing assistant (NA) as R152 had slid towards the ground.

-9/6/18, at 11:08 p.m. R152 had returned to his room from the outside, appeared intoxicated and indicated to facility staff he was intoxicated. The note revealed staff were unable to locate any alcohol in R152's room, he was assisted to bed and encouraged to use his call light for assistance. Further, the note revealed the facility's DON had been notified.

-9/7/18, R152 had been outside and was suspected of drinking alcohol, staff requested to smell his bottle of Gatorade. The note revealed

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R152 had refused and left the facility grounds in his wheelchair. The note revealed R152's sister had been notified, facility administrator and the DON. R152's progress notes did not indicate when R152 returned to the facility, or his condition.

-9/14/18, "Passer-by's" had found R152 on the ground outside the facility, and had assisted R152 back into his wheelchair. The note revealed R152 was assisted back into the building by facility staff. The note revealed R152 had a scratch on his left knee and back of his right hand.

- 9/18/18, R152 had a heavy smell of alcohol on his breath, though was not observed drinking. The note revealed R152 would be monitored that night.

-9/18/18, revealed R152's probation officer had been notified of R152's drinking in the facility, and the note indicated R152's probation officer would speak with the supervisor and call the facility back.

- 9/21/18, R152's probation officer had come to the facility, met with R152 and facility administration. The note revealed shortly after R152 had met with his probation officer, he had left the facility without signing out and was observed to wheel himself to the liquor store. The note revealed the facility social worker had met R152 inside the liquor store where he had a bottle of vodka. The note revealed the facility social worker followed R152 back to the facility and reminded him not to consume alcohol or go to the liquor store. The note revealed R152 nodded in agreement.

-9/24/18, R152's probation officer and supervisor

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had met with R152 and the facility social worker to discuss R152's drinking alcohol. The note revealed a bottle of vodka had been found in R152's top drawer to his nightstand. The note further revealed R152's probation officer had advised the facility to notify them if R152 continued to drink, and informed them they possibly could revoke R152's probation.

- 9/28/18, R152 had been observed to be at a liquor store near the facility, and upon return R152's room fridge was checked, a fifth of vodka was found with 1/3 missing from the bottle. The note revealed the facility DON had been notified and advised to pour the remaining vodka down the sink, and to monitor R152 for the night.

-10/1/18, R152's probation officer had been updated regarding R152's drinking alcohol.

- 10/3/18, an activity care conference note which revealed a concern for R152's drinking issues.

-10/3/18, R152 had met with facilty social worker and probation officer in the facility. The note revealed R152 had been notified if he continued drinking alcohol he would be arrested and returned to jail in North Dakota. A further note revealed R152's probation officer instructed facility staff to notify the local police department if R152 was drinking and the police would contact R152's probation officer.

-10/26/18, R152 had been drinking, and had a violent altercation with a facility staff member.

-11/3/18, R152 had been found on the floor of his room and had slipped out of bed. The note revealed R152 had appeared drunk and had been trying to self transfer. The note revealed

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neurological checks could not be completed due to R152's intoxication.

-11/4/18, R152 had been shouting at staff, and had insisted he wanted to get up in his wheelchair and go outside to smoke. The note revealed R152 had appeared drunk and staff had encouraged him to stay in bed.

-11/10/18, R152 had struck an NA in the shower room and local police had been notified. A later note revealed law enforcement had instructed staff to work with R152 in pairs.

- 11/19/18, R152 had smoked marijuana. The note revealed R152's probation officer was notified, and had indicated they had would give R152 30 days to complete a chemical use assessment.

-12/3/18, a provider progress note had been received and indicated R152 had alcohol abuse disorder, worsening and had a detailed discussion with social worker to abstain from alcohol.

-12/11/18, facility social worker had been notified R152 smelled of alcohol and a bottle of vodka had been found in the bottom of the drawer of his dresser. The note revealed R152's probation officer arrived to the facility, and R152's breathalyzer was 0.035. The note indicated R152's probation officer had notified the local police department, who would not take R152 to jail due to medical conditions, and the county jail nurse had left for the day. The note revealed R152 had been reminded he needed to complete a chemical assessment within 30 days, however R152 acknowleged he would not be completing a chemical dependency assessment, and preferred

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21475	Continued From page 13 to go to jail. -12/15/18, R152 was inebriated, and a soda bottle with alcohol in it had been removed from his room. R152 had been slurring his words. The note revealed the facility contacted local police, a breathalyzer test was given in which R152 had blown a 0.175. The note revealed officers recorded the information and left the facility. -1/2/19, R152 had met with his North Dakota probation officer, and his probation had been lifted. The note revealed at that time R152's Minnesota probation had also been lifted. The note revealed the facility administrator had notified R152's family member his probation had been lifted, and further informed R152's family member "that for now, R152 was still a resident." -1/4/19, revealed the facility had been updated R152 was no longer on probation, and at that time the facility would monitor for periods of intoxication. On 1/3/19, at 2:07 p.m. NA-B stated R152 required extensive assistance with ADL's with assistance of two staff members. She indicated she routinely worked with R152. NA-B stated R152 was able to let staff know of his needs, and he requested when he needed cares completed. She indicated there were times R152 would sleep most of the day, until approximately 2:00 p.m. on most days. NA-B indicated R152 was able to come and go from the facility once he was assisted into his wheelchair. She stated she had been informed by other facility staff R152 had been drinking alcohol in and out of the building, though indicated she had not observed R152 drinking alcohol. She stated she felt he drank in the evenings and night shifts and stated she felt	21475		

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21475	Continued From page 14 he slept into the afternoon due to this. NA-B indicated she was unaware of any monitoring in place for R152's drinking alcohol. On 1/3/19, at 4:46 p.m. NA-C stated R152 required extensive assistance with all cares, and indicated he routinely worked with R152. NA-C stated R152 had a history of falls, though indicated he had not fallen recently. NA-C stated R152 had been intoxicated from alcohol multiple times within the last few months, and stated he had smelled alcohol on R152's breath. He stated he had let the nurse know, and indicated he was unaware of any changes in R152's plan of care since then. NA-C stated R152 was not on routine checks or monitoring for any behaviors of drinking alcohol. On 1/3/19, at 4:51 p.m. trained medication aide (TMA)-D stated R152 had a history of falls which usually occurred when R152 had been drinking. TMA-D stated R152 was not supposed to drink alcohol in the facility, and his probation officer had come out to the facility within the past few months. She stated R152 was recently released from probation, and was unaware of any monitoring in place for R152's alcohol consumption, or suspicion of. TMA-D stated R152 would often become aggressive when he was intoxicated, and indicated when R152 was sober he was cooperative and pleasant. She indicated she felt R152's face would often become red when he was intoxicated, but had shown no other signs other than aggression. TMA-D stated she would contact R152's MD to notify her of any suspicion of intoxication, and would follow up on holding R152's medications if needed. On 1/3/19, at 4:58 p.m. the assistant director of	21475		

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nursing (ADON) stated she had been aware R152 had been drinking alcohol in the facility and had become intoxicated. She indicated R152 often became aggressive when he drank, would sway, and his face would get red. The ADON stated she felt R152's could not transfer safely when he had been drinking, was more prone to self transfers and impulsive behavior. The ADON stated R152's probation officer and police were notified of R152's alcohol consumption and indicated no action had been taken by either parties. The ADON confirmed there were no current interventions or monitoring in place by the facility for R152's alcohol consumption. She further confirmed R152's fall incident reports lacked comprehensive assessment, root cause analysis, monitoring and/or any intervention to provide safety interventions when R152 consumed alcohol.

On 1/3/19, at 1:48 p.m. R152 was seated in his wheelchair near the front entrance by the nurse's station. R152 conversed with another male resident and a female resident. R152 propelled himself towards the front door with the other two residents. R152 propelled himself outside to the facility's resident smoking area.

On 1/3/19, at 5:12 p.m. R152 was seated in his wheelchair by the nurse's station. He was dressed in a coat, stocking cap and tennis shoes. R152 propelled himself from the entryway down the hall towards his bedroom.

On 1/4/19, at 8:38 a.m. R152 was seated in his wheelchair, propelled himself down the hallway towards the front entrance of the facility. R152 was dressed in a coat, stocking cap and tennis shoes. R152 had an unlit cigarette in his right hand.

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21475	Continued From page 16 On 1/3/19, at 5:17 p.m. TMA-B stated R152 had fallen within the past few months and indicated R152 had consumed alcohol within the last few months. TMA-B stated R152 had drank alcohol as recently as a few weeks ago. She indicated she felt R152 became aggressive when he drank, but felt she had a hard time noticing any other way. TMA-B stated R152 would be actively drink at night, and was unsure of when he would actually drink the alcohol. TMA-B stated she had notified the registered nurse at the times R152 had appeared drunk. She indicated she was unaware of any monitoring in place for R152's consumption of alcohol. On 1/3/18, at 5:23 p.m. licensed practical nurse (LPN)-A stated R152 was often very red in the face in the mornings, and stated she felt R152 drank daily and would not show outward signs of drinking until he became aggressive. LPN-A indicated she had searched his room routinely and outside in the facility smoking area, she had found a bottle of liquor in the bench where the fire blanket was kept. LPN-A stated there was no current monitoring in place for R152's consumption of alcohol and/or safety. On 1/3/19, at 5:38 p.m. TMA-C stated she had worked with R152 for approximately the last seven months, and indicated she was unaware if R152 had consumed alcohol at any time in the last seven months. TMA-C stated she was not aware of any safety interventions in place for R152. On 1/4/19, at 7:55 a.m. the facility administrator stated he had been aware of R152's continued alcohol consumption, and had met with the IDT team. He confirmed at the time of the survey,	21475		

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21475	Continued From page 17 R152 had declined a chemical dependency assessment, and was unaware of any interventions in place to monitor R152's alcohol consumption and safety. The administrator stated the facility's social service director had resigned as of 12/24/18, and stated he was unaware of any other interventions or other measures taken to monitor and ensure the safety of R152 when he consumed alcohol. On 1/4/19, at 9:00 a.m. the Regional Director of Clinical Services (RDCS) confirmed R152 was not currently monitored for alcohol intoxication or for safety. She stated R152 last drank a few weeks ago, and indicated she felt R152 drank very little and would get very happy when he drank. The RDCS stated she felt R152 was not aggressive when he drank, and would try to interact with staff more so when he was intoxicated. The RDCS indicated she had discussed R152's case with the DON at a sister facility as the facility "deals with residents" with chemical dependency. She indicated she did not feel R152's alcohol consumption and intoxication increased his risk for falls, and felt other residents may have enticed R152 to drink. The RDCS indicated she felt R152's impulse control and safety awareness were affected by R152's alcohol consumption and intoxication. RDCS confirmed previous care plan did not given direction for his alcohol consumption. On 1/4/19, at 1:03 p.m. R152's physician (MD)-B returned a telephone call and left a message for a return call. At 3:12 p.m. a telephone interview was conducted with MD-B. MD-B confirmed she was R152's primary physician and had not recently been in the facility to see him. MD-B stated she had recommended R152 be sent to a rehab center for his alcohol consumption in the past.	21475		

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21475	Continued From page 18 MD-B stated she felt R152's drinking had worsened, and indicated he would become very aggressive when drinking. She indicated she was not aware if R152 had refused treatment and stated if he had, she would expect the facility to implement strong monitoring to ensure R152's safety. MD-B stated she had overall concerns with the management, administration, and nursing staff of the facility. She indicated she had concerns with the facility's ability to care for the residents and indicated the staff would often not follow through with her orders and or direction. MD-B stated she felt the residents within the facility were at risk and feared for their safety. A facility policy titled Alcohol and Drug Policy, created 9/21/18, directed it was the policy of the facility to provide care to residents who required chronic disease management. The policy directed it was the facility's responsibility to ensure the safety of residents, and if drugs or alcohol had been determined to compromise safety, the facility would implement approaches to address the safety concerns. The policy indicated the use and possession of illegal drugs or alcohol were strictly prohibited. The policy revealed the facility would allow a controlled amount of alcohol to be consumed by residents under the direction of the provider. The policy listed various interventions and approaches to be provided to the resident if alcohol or drug consumption was identified; assessing triggers, warning systems, counseling, managed risk, chemical dependency or detox referral, sending resident to the emergency room if there behavior puts themselves, other residents or staff at risk, additional staff training and considering discharge with a safe discharge plan. SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review	21475		

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21475	Continued From page 19 and/or revise facility policies and procedures related to medically related social services. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward supporting the social service needs of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for social service needs. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21475		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults 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 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	21980		2/1/19

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21980	Continued From page 20 in section 626.5572, subdivision 21, 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 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 agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead 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 document review, the facility failed to ensure an allegation of abuse was reported immediately, but no later than 2 hours, to the State Agency (SA) for 1 of 1 resident (R35) who was reviewed for allegations of rough handling during care. Findings include:	21980	corrected	

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21980	Continued From page 21 R35's quarterly Minimum Data Set (MDS) assessment dated 10/10/18, identified R35 had moderate cognitive impairment and diagnoses which included arthritis, and pain. R35's annual Care Area Assessment (CAA) dated 10/16/18, indicated R35 was receiving hospice services, and had a cognitive decline recently likely due to end of life disease process, and further indicated R35 was vulnerable due to her cognitive loss. Additionally, the CAA indicated R35 had physical limitations and required extensive assistance from 1 staff and utilized a hoyer (full body lift device) for transfers. Review of the incident report submitted by the facility by the administrator on 12/31/18, at 12:51 p.m. revealed R35's family member (FM)-A had reported that NA-A was "rough" with R35 during a transfer, and indicated R35 said "Ow, ow, ow" during cares. FM-A had reported nursing assistant (NA)-A was rushed and "verbally abrasive" to R35. The report further indicated the facilities immediate action to protect the resident was NA-A was removed from R35's care. On 1/3/19, at 1216 a.m. during a telephone interview, FM-A stated they were visiting R35 on 12/30/18, around 4:00 p.m. when R35 requested to go to bed. FM-A indicated licensed practical nurse (LPN)-A entered the room and assisted R35 to transfer into bed with the hoyer. Then, NA-A entered the room, and LPN-A left the room. FM-A stated NA-A was assisting R35 to remove the sling, and grabbed R35's left shoulder and started to pull R35 over when R35 called out "Ow,ow,ow" in pain. FM-A stated NA-A did not stop to check on what was the causing R35 to call out in pain, or ask R35 what was wrong.	21980		

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21980	Continued From page 22 FM-A stated NA-A was in a hurry and in an abrasive tone and told R35, "The sooner you roll over, the sooner we can get it out of here." FM-A stated she had observed the black square hard plastic hook from the sling that attached to the hoyer poking R35 in the back, and moved it out of the way so she could roll over it, and asked NA-A to leave. FM-A stated she saw no redness on R35's back after the sling was removed. FM-A stated after NA-A left R35's room, she immediately reported the incident to LPN-A, and requested NA-A not provide care for R35 anymore. During interview on 1/3/19, at 1:09 p.m. the administrator stated the incident was reported to him immediately on 12/30/18, at 4:25 p.m. The administrator stated he had interviewed LPN-A, and NA-A for the initial intake and stated he did not view the incident as abuse. The administrator stated it was alleged abuse, and indicated he did not feel willful abuse had occurred. The administrator stated FM-A had reported NA-A was "rough" with care of R35. The administrator verified R35's abuse allegation reporting was late and was not filed until the following afternoon. The administrator stated all allegations of abuse need to be reported within 2 hours, but explained he had issues with submitting the report on 12/30/18. The administrator verified he was responsible for submitting the reports, and stated he would expect all reports to be completed within 2 hours. The administrator stated he did not feel the incident was abuse, and stated FM-A felt NA-A was rushed and was "verbally abrasive," and stated NA-A was not aggressive but was "verbally abrasive" when she told R35, "If you hurry up and help roll over it could get done sooner".	21980		

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21980	Continued From page 23 On 1/3/19, at 3:15 p.m. NA-A stated she worked with R35 that day (1/3/19) and indicated she had just brought R35 to the dining room. NA-A stated she was aware of a complaint of rough handling, but was not aware of any restrictions from providing care to provide care for R35. NA-A stated LPN-A and FM-A had assisted R35 into bed with the hoyer. NA-A stated LPN-A left the room when she arrived, and FM-A remained in the room. NA-A stated when she rolled and tucked the sling behind R35 to remove the sling R35 said "ow ow". NA-A stated FM-A asked R35 what was wrong, started crying, and told NA-A to leave. R35 stated "I have never had a complaint on me before", and indicated she was trying to be careful and tuck the sheet when she rolled R35. NA-A stated LPN-A told her to stay away from R35, but indicated 2 times she had tried to go back to R35's room to apologize. A review of NA-A's employee record revealed she had started working in the facility in 2012. NA-A had received abuse/neglect training annually, with the most recent recorded date of 4-24-18. A facility document titled Golden Living Action Log indicated NA-A had been reported for resident abuse/neglect on 2/11/2015, the complaint was unsubstantiated and no disciplinary action was taken. On 1/3/19, at 4:30 p.m. during a follow up interview with the Administrator, he stated the alleged "rough" handling of R35 could have been potential abuse. The Administrator indicated after initial staff interviews he had determined it was not "intentional harm", and no "willful abuse" had occurred, and stated it was "hurried care, not abuse". On 1/4/19, at 8:47 a.m. assistant director of	21980		

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21980	Continued From page 24 nursing (ADON) stated the administrator was in the building at the time of the incident and stated she would expect a report to be filed with the SA within 2 hours, then an investigation to be done. A review of the facility policy titled Resident Protection Manual revised 8/2/18, under the section titled "Reporting and Response" indicated allegations that involve abuse, neglect or mistreatment are reported immediately, but not later than 2 hours after the allegation is made. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to abuse prohibition. Responsible personnel could be re-educated on these policies and procedures. Reports of abuse/neglect/injuries of unknown origin could be reviewed for compliance with these policies, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying	22000		2/1/19

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22000	Continued From page 25 factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.	22000		

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22000	Continued From page 26 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures to ensure the State Agency (SA) was immediately notified, no later than 2 hours following an allegation of physican/verbal abuse for 1 of 1 resident (R35) reviewed for allegations of abuse. In addition, the facility policy failed to provide clear guidelines for protection of the resident(s), during completion of a thorough investigation. Findings include: The facility policy titled Resident Protection Manual revised 8/2/18, directed procedures must be in place to provide the resident with a safe, protected environment until the investigation is completed. The policy indicated social services should keep in constant contact with the resident and/or representation, if the resident could be at risk in the same environment, evaluate the situation and consider some options including a room change or roommate change, if a family member is possibly contributing to the potential abuse and the resident could be at risk, evaluate the situation and consider some options including altered visitation. The policy further directed prior to the completion of the incident reporting process, the licensed nurse and staff will assure that the resident(s) involved are safe, removed from harm, protected from further incident and that their rights are protected. Further, the policy directed if alleged abuse occurs staff will: take immediate action to protect the individual(s) involved including removal of alleged abuser.	22000	corrected	

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22000	Continued From page 27 However, the policy lacked clear guidelines for protection of all residents in the facility from potential abuse from the staff member while the investigation of the allegation of abuse was conducted. Review of the incident report submitted by the facility by the administrator on 12/31/18, at 12:51 p.m. revealed R35's family member (FM)-A had reported that NA-A was "rough" with R35 during a transfer, and indicated R35 said "Ow, ow, ow" during cares. FM-A had reported nursing assistant (NA)-A was rushed and "verbally abrasive" to R35. The report further indicated the facility's immediate action to protect the resident was NA-A was removed from R35's care. During an interview on 1/3/19, at 1:09 p.m. the administrator stated he had interviewed LPN-A, and NA-A for the initial intake, and stated he did not view the incident as abuse. The administrator stated it was "alleged abuse," and indicated he did not feel "willful abuse" had occurred. The administrator stated FM-A had reported NA-A was "rough" with care of R35, and FM-A felt NA-A was "verbally abrasive." The administrator stated NA-A was not aggressive but was "verbally abrasive" and told R35, "If you hurry up and help roll over it could get done sooner." The administrator indicated he felt he did not need to remove NA-A from contact with R35 or the other residents, because he did not feel it was abuse. The administrator stated LPN-A took immediate action to remove NA-A from providing care for R35 for the remainder of that shift. The administrator verified NA-A was removed from care for only R35 for that shift, and continued to provide care for other residents in the facility. On 1/3/19, at 4:30 p.m. during a follow up	22000		

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22000	Continued From page 28	22000		

interview with the administrator, he stated the alleged "rough" handling of R35 could have been potential abuse. The administrator indicated after the initial staff interviews he had determined it was not "intentional harm," and no "willful abuse" had occurred, and stated it was "hurried care, not abuse." The administrator stated he felt R35 had been protected by removing NA-A from providing care for that shift, and indicated the facility had not put restrictions or monitoring of NA-A cares in place. The administrator stated no other interviews of staff or residents in the facility had occurred during his investigation of rough handling and abrasive language of R35.

On 1/4/19, at 8:47 a.m. assistant director of nursing (ADON) stated the administrator was in the building at the time of the incident, and had interviewed LPN-A and NA-A within minutes of being notified of the abuse allegation. The ADON stated after the administrator interviewed those staff, he had concluded abuse did not occur. The ADON stated she felt NA-A would need retraining on safe patient handling and resident interactions. The ADON stated her understanding of the facility policy and what should occur in the event of an alleged abuse or neglect complaint/concern was the resident(s) safety is ensured by removing the alleged perpetrator from the immediate care of the resident(s), the alleged perpetrator would be sent home until further notice pending investigation, then an investigation is done. The ADON stated after completion of the investigation, if the allegation is unsubstantiated and it is determined the staff can return to work, retraining and education should be completed before the staff is allowed to provide any direct care for residents. The ADON verified that NA-A had not been removed from having access to R35 or the other residents in the building after the

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22000	Continued From page 29 incident. ADON stated as of 1/4/19, NA-A had been reassigned to other resident groups, and was not aware NA-A provided direct care for R35. SUGGESTED METHOD OF CORRECTION: The administrator could develop policies and procedures regarding reporting and investigating all alleged abuse/neglect/mistreatment. The administrator could educate all staff on those policies and procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		