Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 13, 2020

Administrator
Texas Terrace A Villa Center
7900 West 28th Street
Saint Louis Park, MN 55426

RE: CCN: 245187
Cycle Start Date: January 16, 2020

Dear Administrator:

On January 16, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by April 16, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 16, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING ______ B. WING ______	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE A VILLA CENTER	**7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426**

(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 On 1/15/2020, to 1/16/2020, a abbreviated standard survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints was found to be substantiated: H5187122C, and H5187123C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 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	F 609		3/3/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/21/2020

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

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F 609	Continued From page 1 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 facility failed to ensure incidents of resident to resident abuse was immediately, no later than two hours, reported to the State agency (SA) for 2 of 3 incidents(R1, R2, R3) reviewed. Findings include: R1's quarterly Minimum Data Set (MDS) dated 10/17/19, indicated R1 had cognitive impairment and had diagnoses including manic depression, adult antisocial behavior, adjustment/conduct disorder, and diabetes. The MDS indicated R1 required supervision with bed mobility, transfers, and toileting and had verbal behavior including threatening, screaming, or cursing directed at others. R1's care plan dated 1/13/2020, identified	F 609	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusion in the statement of deficiencies. This plan of correction is prepared and executed as a means to continually improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facilitates allegation of compliance. All allegations of neglect, abuse, exploitation or mistreatment must be reported to the facility administrator immediately after any concern have been expressed, witnessed or suspected and instruct staff to provide protection as needed. The Facility will file reports with	

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F 609	Continued From page 2 behaviors including sexually inappropriate comments, and physical/verbal altercations towards residents and staff. The care plan instructed staff to complete behavior monitoring and intervene when R1 has behaviors by telling him to stop, removing R1 from the area, and notify the director of nurses (DON), Administrator, guardian, and call 911 before R1 escalates. R2's admission Minimum Data Set (MDS) dated 11/1/19, indicated R15 was cognitively intact and had diagnoses including dislocation of the right hip, acute kidney failure, hypertension, and chronic obstructive pulmonary disease. The MDS indicated R2 required extensive assistance of 2 staff with bed mobility, toileting and transfers, and required extensive assist from 1 staff with locomotion on and off the unit. R2's admission CAA 11/1/19, indicated R2 was alert/oriented, able to express needs to staff. The CAA identified R2 was at risk for falls related to history of falls and problems with balance requiring staff assistance to stabilize from seated to standing position, moving on and off toilet and transferring from surface to surface. R2's care plan dated 1/13/2020, included various interventions and included history of physical behavior altercations with other residents and indicated staff would complete a root cause analysis of the circumstances, triggers, and provide interventions and instructed staff to monitor/document and report to the provider. During an interview on 1/16/2020, at 9:43 a.m. R2 stated she and other residents had been	F 609	in the time frame. The IDT will then complete investigations. The IDT members have reviewed the procedure for reporting. Staff members have received re-education about who to call, the need to report timely, what is abuse and review of concerns/grievances that have been received. The employee responsible for the late reporting is no longer employed by the facility. The facility granted remote access to additional staff to allow for monitoring changes, persons added include the nurse managers, unit director and social services. The Administrator, Director of Nursing or designee will audit all concerns and grievances for timeliness and completion for two weeks, then two OHFC reports for four weeks or until resolved by the QAPI committee. All results to be be shared at QAPI	

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F 609	Continued From page 3	F 609		

bullied by R1. R2 indicated R1 will grab or lunge at her breasts or bottom and call her filthy names like cunt, and bitch on a daily basis. R2 stated on the day of the incident R1 was calling her "cunt" more than 20 times, and indicated staff and other residents were present at the time, and no one intervened to redirected R1. R2 stated she was frustrated and warned R1 to stop or she would throw milk at him. She stated she had had enough and when R1 called her cunt one more time she did just that. R2 stated she was walking away when she heard him behind her and turned to look and he swung and hit her with his forearm on the left side of her face. R2 stated R1 was removed from the room by staff and she went to sit down in the common area. R2 stated she was scared and no one had come to check on her or see if she was ok and called 911. R2 stated there was no redness or bruises on her face.

A review of the Incident Report submitted to the state agency (SA) indicated the incident had occurred on 1/6/2020, at 9:00 a.m. but was not submitted to the SA until 1/6/2020, at 2:18 p.m.

During a interview on 1/16/2020, at 1:02 p.m. with the director of nurses (DON) and Administrator, the DON stated it was her understanding of the facility abuse policy procedure that allegations suspicion of abuse would need to be reported with in 24 hours unless serious bodily harm had occurred. The DON and Administrator verified the facility provided policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property", and dated 11/28/2017, was the current policy and upon review verified the policy instructed facility staff to report all

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F 609	Continued From page 4 allegations/suspicion of abuse with in 2 hours. The Administrator stated she would expect the policy to be followed. In addition, the DON verified she had not submitted the incident to the SA per policy. R3's Admission MDS dated 10/15/19 indicated R3 had moderate cognitive impairment and did not indicate any behavioral issues and required supervision for ADL's. Review of Nursing Home Incident Report (NHIR) dated 1/12/2020, at 9:22 a.m. indicated at 1/11/2020, @ 4:43 p.m. R1 was having an argument with a female resident when R3 came to defend the female resident. Staff separated R1 from R3 and the female resident. R1 returned to the common area unnoticed, went up to R3, and hit R3 in the head knocking his glasses off his head. The time elapsed from the incident to when it was reported to the state agency was 16 hours and 39 minutes. A review of the facility provided policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property", and dated 11/28/2017, instructed staff to report all alleged violations of abuse immediately but no later than 2 hours to the SA. In addition, the policy instructs staff investigate and provide documentation of the incident investigation including date, time, location and circumstances of the incident including injuries, steps taken to protect the resident, and reporting notification to	F 609		

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F 609	Continued From page 5 the provider.	F 609		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
February 13, 2020

Administrator
Texas Terrace A Villa Center
7900 West 28th Street
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: Z61B11

Dear Administrator:

The above facility was surveyed on January 15, 2020 through January 16, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF

CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

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

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

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

Please feel free to call me with any questions.

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

Minnesota Department of Health

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 1/15/2020, to 1/16/2020, a abbreviated standard survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.

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2 000	Continued From page 1 The following complaint was found to be substantiated: H#5187122C, and H5187123C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	2 000		
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		3/3/20

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21980	Continued From page 2	21980		

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 incidents of resident to resident abuse was immediately, no later than two hours, reported to the State agency (SA) for 2 of 3 incidents(R1, R2, R3) reviewed.

Findings include:

All allegations of neglect, abuse, exploitation or mistreatment must be reported to the facility administrator immediately after any concern have been expressed, witnessed or suspected and instruct staff to provide protection as needed. The Facility will file reports with in

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	00144	A. BUILDING: ______ B. WING ______	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE A VILLA CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 3 R1's quarterly Minimum Data Set (MDS) dated 10/17/19, indicated R1 had cognitive impairment and had diagnoses including manic depression, adult antisocial behavior, adjustment/conduct disorder, and diabetes. The MDS indicated R1 required supervision with bed mobility, transfers, and toileting and had verbal behavior including threatening, screaming, or cursing directed at others. R1's care plan dated 1/13/2020, identified behaviors including sexually inappropriate comments, and physical/verbal altercations towards residents and staff. The care plan instructed staff to complete behavior monitoring and intervene when R1 has behaviors by telling him to stop, removing R1 from the area, and notify the director of nurses (DON), Administrator, guardian, and call 911 before R1 escalates. R2's admission Minimum Data Set (MDS) dated 11/1/19, indicated R15 was cognitively intact and had diagnoses including dislocation of the right hip, acute kidney failure, hypertension, and chronic obstructive pulmonary disease. The MDS indicated R2 required extensive assistance of 2 staff with bed mobility, toileting and transfers, and required extensive assist from 1 staff with locomotion on and off the unit. R2's admission CAA 11/1/19, indicated R2 was alert/oriented, able to express needs to staff. The CAA identified R2 was at risk for falls related to history of falls and problems with balance requiring staff assistance to stabilize from seated to standing position, moving on and off toilet and transferring from surface to surface.	21980	the time frame. The IDT will then complete investigations. The IDT members have reviewed the procedure for reporting. Staff members have received re-education about who to call, the need to report timely, what is abuse and review of concerns/grievances that have been received. The employee responsible for the late reporting is no longer employed by the facility. The facility granted remote access to additional staff to allow for monitoring changes, persons added include the nurse managers, unit director and social services. The Administrator, Director of Nursing or designee will audit all concerns and grievances for timeliness and completion for two weeks, then two OHFC reports for four weeks or until resolved by the QAPI committee. All results to be be shared at QAPI	

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21980	Continued From page 4	21980		

R2's care plan dated 1/13/2020, included various interventions and included history of physical behavior altercations with other residents and indicated staff would complete a root cause analysis of the circumstances, triggers, and provide interventions and instructed staff to monitor/document and report to the provider.

During an interview on 1/16/2020, at 9:43 a.m. R2 stated she and other residents had been bullied by R1. R2 indicated R1 will grab or lunge at her breasts or bottom and call her filthy names like cunt, and bitch on a daily basis. R2 stated on the day of the incident R1 was calling her "cunt" more than 20 times, and indicated staff and other residents were present at the time, and no one intervened to redirected R1. R2 stated she was frustrated and warned R1 to stop or she would throw milk at him. She stated she had had enough and when R1 called her cunt one more time she did just that. R2 stated she was walking away when she heard him behind her and turned to look and he swung and hit her with his forearm on the left side of her face. R2 stated R1 was removed from the room by staff and she went to sit down in the common area. R2 stated she was scared and no one had come to check on her or see if she was ok and called 911. R2 stated there was no redness or bruises on her face.

A review of the Incident Report submitted to the state agency (SA) indicated the incident had occurred on 1/6/2020, at 9:00 a.m. but was not submitted to the SA until 1/6/2020, at 2:18 p.m.

R3's Admission MDS dated 10/15/19 indicated R3 had moderate cognitive impairment and did not indicate any behavioral issues and required

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21980	Continued From page 5 supervision for ADL's. Review of Nursing Home Incident Report (NHIR) dated 1/12/2020, at 9:22 a.m. indicated at 1/11/2020, @ 4:43 p.m. R1 was having an argument with a female resident when R3 came to defend the female resident. Staff separated R1 from R3 and the female resident. R1 returned to the common area unnoticed, went up to R3, and hit R3 in the head knocking his glasses off his head. The time elapsed from the incident to when it was reported to the state agency was 16 hours and 39 minutes. During a interview on 1/16/2020, at 1:02 p.m. with the director of nurses (DON) and Administrator, the DON stated it was her understanding of the facility abuse policy procedure that allegations suspicion of abuse would need to be reported with in 24 hours unless serious bodily harm had occurred. The DON and Administrator verified the facility provided policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property", and dated 11/28/2017, was the current policy and upon review verified the policy instructed facility staff to report all allegations/suspicion of abuse with in 2 hours. The Administrator stated she would expect the policy to be followed. In addition, the DON verified she had not submitted the incident to the SA per policy. A review of the facility provided policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property", and dated 11/28/2017, instructed staff to report all	21980		

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21980	Continued From page 6 alleged violations of abuse immediately but no later than 2 hours to the SA. In addition, the policy instructs staff investigate and provide documentation of the incident investigation including date, time, location and circumstances of the incident including injuries, steps taken to protect the resident, and reporting notification to the provider. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures for vulnerable adult reporting, educate staff on these policies and audit to ensure compitency and understanding periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21980		