DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 31, 2020

Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, MN 56716

RE: CCN: 245251
Cycle Start Date: October 22, 2020

Dear Administrator:

On December 8, 2020, we notified you a remedy was imposed. On December 29, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 21, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 23, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 9, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 23, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 21, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

Electronically delivered

December 8, 2020

Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, MN 56716

RE: CCN: 245251
Cycle Start Date: October 22, 2020

Dear Administrator:

On November 9, 2020, we informed you that we may impose enforcement remedies.

On November 19, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) , as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 23, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 23, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 23, 2020.

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

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 23, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Riverview Hospital & Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 23, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 22, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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
	245251	A. BUILDING _____ B. WING _____	C 11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

(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 11/17/20, through 11/19/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5251030C with a deficiency cited at F600. 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 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		12/21/20

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

Electronically Signed | 12/18/2020

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 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess resident (R1) behaviors in an effort to prevent resident to resident abuse and failed to provide adequate supervision resulting in R1 abusing 3 residents (R2, R3, R4). This resulted in psychosocial harm for R2 , who had isolated themselves to their room and declined activity participation as a result of continued fear of R1. Findings include: R1's admission Minimum Data Set (MDS) dated 7/31/20, identified physical behavioral symptoms directed toward others that occurred daily. The MDS indicated R1's behaviors put others at risk for injury and significantly disrupted the living environment. R1's Care Area Assessment (CAA) dated 7/31/20, identified a history of Alzheimer's with behavioral disturbance and indicated R1 could be physical with staff during cares. The CAA indicated R1's behaviors were related to being fearful in a new situation and frustration related to an inability to communicate wants and needs. R1's quarterly MDS dated 10/28/20, indicated she was severely cognitively impaired, displayed physical behaviors toward others 4-6 days during the assessment period and other behaviors not directed toward others 4-6 days. The MDS indicated R1 ambulated on the unit independently with supervision. R1's care plan dated 11/13/20, identified cognitive	F 600	We have identified 2 residents that need to be overseen to assure that all practices are specific to their situation. Comprehensive nursing assessments have been completed on these residents and from that we have developed care plans to meet each individuals needs. R1 comprehensive assessment revealed that the following interventions are indicated; 1. We first began with medical clearance which included lab work that revealed evidence of a complicated urinary tract infection. This infection was first treated with CIPRO and Levofloxacin. The culture revealed the bacteria was resistant to stated antibiotics and a 72 hour antibiotic timeout was completed and sent to Dr. Fasharo her primary care physician. All other labs were noted to be unremarkable. Resident was also then started on Cefdinir on 11/05/2020 related to the UTI and a CT of the chest cavity resulting abnormally. 2. Psychiatric visits were also reviewed and done in a timely fashion. Dr. Tsibulsky indicated medication changes on 11/09/2020 which included adding Celexa 5mg PO daily and Risperdal 0.25mg twice a day as needed for agitation with a follow up in 3-4 weeks. Since the initiation of	

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F 600	Continued From page 2 loss/dementia and indicated she displayed physical behavioral symptoms toward others including entering resident rooms and eating food and drinking their liquids. The care plan directed staff to follow familiar routines such as frequent snacks, assess whether behaviors endangered herself or others and intervene as needed, provide 30 minute rounding and provide R1 with music of her personal interest. The care plan further indicated R1 received medications related to violent behavior and Alzheimer's disease and identified target behaviors that included wandering, exit seeking, rummaging, entering others rooms and hitting. Care planned interventions included monitor behavior and response to medication, assess effectiveness of drug treatment and psychiatric treatment. R2's quarterly MDS dated 9/15/20, identified moderate cognitive impairment and minimal depression. R2's MDS indicated she required supervision for transfers and ambulation and displayed no behaviors during the assessment period. R2' care plan dated 10/30/20, identified cognitive loss/dementia and indicated a fear/paranoia of others entering her room. The care plan directed staff to provide 30 minute checks to ensure she felt safe in her environment. The care plan further identified R2's family wanted to discharge her to an alternate long term care facility. An Investigation Report Summary dated 10/16/20, indicated R1 wandered up and down care center hallways throughout the day. Most recent interventions included offering food and drink when wandering. Intervention had been placed after R1 was seen in R2's room eating her	F 600	Celexa the occurrences of wandering have decreased significantly. At this time R1 is able to be easily redirected with decreased signs/symptoms of aggression. 3. Based upon physician recommendations we are considering other facilities that could perhaps better meet her needs. She is on a waiting list for Reflections in Staples at this time. The status of the waiting list is checked once weekly. 4.Activity Director will lead the staff on the following interventions: a. We have procured a sewing machine that R1 and other residents can utilize safely. Admission assessments showed an interest in sewing on the part of R1 and this familiarity will engage her in meaningful and purposeful activity. b. A Sensory Owl (a multi-sensory board) is available for individual usage as well as programed times. This will give R1 the opportunity to keep her hands occupied when relaxing. This will also be beneficial for maintaining motor skills and having sensory input. c. The iPod shuffle has been moderately successful but will be enhanced by using it proactively rather than after a display of anxiousness and wandering. d. Resident R1 will have 1:1 visits at least weekly. This will allow her to engage in personalized activities of interest. e. Resident R1 has developed special interest in football and televised church services. These are offered to her on a regular basis. We currently follow the NFL	

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F 600	Continued From page 3 food. After the most recent altercation it was determined R1 was exit seeking and became frustrated when the doors would not open and would turn and enter R2's room as it was nearest room to the exit door. R1 expressed her frustration by grabbing R2's wrist. R2 was placed on 30 minute safety checks and a wanderguard was ordered to be placed to notify staff when R1 was wandering near R2's door. R2 sustained bruising to her left arm measuring 0.5 centimeters (cm) x 0.5 cm, 3 cm x 1 cm, both dark purple in color, two bruises 3 cm x 1.5 cm, 3 cm x 1 cm, both dark purple in color and two more bruises 0.5 cm x 0.5 cm and 0.2 cm x 0.2 cm. An Investigation Report Summary dated 10/29/20, indicated R1 was frequently found wandering into other resident rooms. On 10/29/20, R2 was heard screaming and found R1 in R2's room swatting at her. R2 had entered her room at the same time R1 was exit seeking and when R1 turned around, she entered R2's room and began moving items. R1 grabbed R2's wrist which resulted in the two residents swatting at each other. The report indicated a "rummage room" was put together and had been successful in limiting R1's wandering and referral made to a geriatric psychiatric unit. Bruising related to the event included 2 cm x 1.9 cm, 0.4 cm x 0.2 cm, 0.5 cm x 0.7 cm, 0.2 cm x 0.3 cm and 0.3 cm x 0.3 cm all to R2's right wrist. R2's Resident Progress Notes identified the following: - 8/6/20, at 9:55 a.m. staff heard R2 "hollering" outside of her room and was continuously hitting her right hand into the wall. R1 had entered R2's room causing R2 to become upset. R2 stated,	F 600	schedule and Sunday morning televised church services. 5. Through the Resident Council in December a confidential survey will be conducted 1:1 due to Covid-19, to assess resident level of comfort and security. For residents that are unable to answer safety questions, administrator or designee will reach out and discuss questions. 6. Monitoring further behavioral trends for R1 as she is now indefinitely on the IDT agenda. On 12/02/2020 the IDT team reviewed R1 comprehensively in regards to moisture associated skin damage with signs of improvement as well as PRN Haldol orders and Celexa medication that had been scheduled. 7. Pain and behavioral symptoms show no correlation between moisture associated skin damage and aggressive outbursts with non-staff personal. R1 will most likely have some discomfort related to perineal cares along with possible outbursts with staff. 8.Through IDT it was identified that R1 responds well in a low stimulated location during meal times as indicated by the incident with R3. 9. R2 has been discharged from this facility. 10. R4 has been discharged from this facility.	

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F 600	Continued From page 4 "I'm God damn 80 years old and I have to put up with this bull**** all the damn time." R2 further stated, "[R1] came into my room and s*** all over the damn floor." - 8/16/20, Staff reported R2 had been exit seeking and stating, "I'm getting out of here." - 8/19/20, R2 expressed distress after R1 had gone into her room and would not leave. R2 later asked staff, "when is this nonsense going to stop?" - 8/27/20, R2 was heard screaming down the hall, R1 was wandering and entered R2's doorway. R2 screamed again a while later when R1 was again outside her door. R2 appeared angry and stated, "I can't live like this anymore, you keep her away from here." R2 stated she wanted to go home. - 9/1/20, R2 returned to her room in the afternoon and screamed. Staff went to room and observed R1 in R2's room eating R2's food. R2 told staff she was upset and wanted R1 out of her room. - 9/6/20, R2 screamed from her room. Staff responded to find R1 in R2's room touching her things. Afterward, R2 went to the nurses station and reported how frightened she was of R1 because of her height and felt R1 could hurt her if she became angry. R2 apologized for screaming but stated, "I don't know what else to do, I'm sick of it." - 9/27/20, R2 was heard screaming "HELP" from her room at 9:15 p.m. When staff entered the room R1 was coming out of R2's room. R2 was sitting up in bed with the blankets pulled down a little. When asked what happened, R2 stated R1	F 600	11. Staff will be required to complete and be re-trainied via Educare on Abuse Prevention by 12/21/2020. 12.R3 was assessed through RN Psychosocial Well-Being/Mood Comprehensive Nursing Assessment on 12/21/2020. The findings led to the interventions listed: a. R3 will be offered a room tray at meal times when displaying bouts of agitation, aggression, and refusal for socialization. b. R3 will have completed RN Psychosocial Assessments Quarterly and as indicated also as needed initiated by an RN. 13. The activities director and/or designee will audit activity participation of R1 and R3 1X weekly for four consecutive weeks to ensure that care planned activities are meaningful and successful for the identified residents. The activities director will review R1 and R3 if activities are proven to be unsuccessful in resident participation or for redirection of resident. 14. R3's behavioral symptoms will be monitored and assessed as well as responses to medications by the charge nurse 1X per week while on psychotropics and as needed for any acute behavioral distress.	

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F 600	Continued From page 5	F 600		

had come at her with a knife. R1 did not have a knife but had towels in her hands. R2 voiced concerns about her safety.

- 10/4/20, An unidentified nursing assistant (NA) reported R2 was emotional and upset/scared to go back to her room as a couple of residents kept going into her room.

-10/5/20, at 6:20 a.m. R2 was heard screaming from outside her room. Staff responded to find R1 coming from the room. R2 was upset and stated she did not feel safe.

-10/5/20, at 3:29 p.m. administrator was informed that a resident was screaming. Administrator entered the unit and heard screaming coming from R2's room and found R1 in R2's room wandering. R2 stated she was scared of R1 as R1 wandered into the room daily.

-10/14/20, R2 was heard screaming for help. Staff responded to find R1 attempting to go onto R2's room. R2 stated she was upset and said R1 had been going into her room multiple times and had "squeezed" her hands. R2 stated she felt afraid of R1 but stated she had not been hurt. R2 again stated she was scared of R1.

- 10/15/20, R2 was feeling very "down", refused to allow staff with cares and requested a room tray for both breakfast and lunch.

- 10/15/20, at 4:15 p.m. R2 was heard hollering from her room. Staff rushed to the room and found R2 "shaking, with tears in her eyes and stating, I can't put up with this anymore, just let me go." "She [R1] attacked me!" R2 stated R1 had come to her room and grabbed her on the

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RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

(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 600	Continued From page 6	F 600		

left arm. R2 had bruising consistent with her statement. R1 was redirected and R2 was brought to the nurses station as she was very shaken by the event.

- 10/17/20, R1 wandered into R2's room and sat in her chair. R2 was upset. 30 minute checks in place.

- 10/18/20, R2 was heard screaming in her room. R1 had wandered into R2's room.

- 10/24/20, R2 became upset before breakfast when R1 wandered into her doorway. R2 stated she was sick of things around there and stated she did not want to eat breakfast in the dining room.

- 10/25/20, R2 screamed a couple of times during the shift to let staff know R1 was approaching her room.

- 10/27/20, At approximately 4:30 p.m. administrator heard a scream from the unit and ran to see what was going on. R1 was in R2's room "swatting at her." R2 began to immediately bruise on the right wrist and stated R1 entered her room, walked around and proceeded to grab onto her wrist.

- 11/1/20, R2 appeared to be more depressed. R2 had been sleeping later and after getting ready for the day requesting to go back to bed. R2 ate poorly at lunch after requesting a room tray and spent all day in her room.

- 11/2/20, Staff spoke with charge nurses regarding R2's depressive episodes over the weekend.

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F 600	Continued From page 7 - 11/4/20, Staff noticed R2 standing behind her door while another resident was near her doorway. R2 stated, "Don't let him in." - 11/9/20, R2 told staff she felt "unsafe" when R1, who she had a previous altercation with was walking by her. - 11/10/20, Staff informed primary care provider that R2's power of attorney was looking for alternate placement for her. During interview on 11/18/20, at 9:36 a.m. R2's family member (FM)-A stated she was very upset and did not trust the facility to take care of R2. FM-A stated she was looking for another facility for R2. FM-A stated she was angry because the facility had not done anything to protect R2 and all they wanted to do was move R2 to a different room. At 10:20 a.m. R2 stated she had been at the facility for a few years and stated some of the things at the facility were "really shitty." R2 stated, "I've got one lady, she beats on me." R2 stated it had happened more than once and she had been hurt. R2 stated, "The people that work here don't do a lot when I can't even go outside the room and someone comes and throttles you." R2 stated she had bruises and said she [R1] was strong and when [R1] got a grip on her she couldn't get out of it. R2 stated she did not want to complain and said her "fear" of R1 was why she spent so much time in her room. R2 identified R1 by name and said, "I am afraid of her coming down here, she has attacked me in my room, as recently as a week and a half ago."	F 600		

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At 10:33 a.m. activity assistant (AA)-A stated during the day R1 rested a lot but she noticed that R1 would get up between 3:00 p.m. and 4:00 p.m. and start wandering around. AA-A stated R1 was more ambulatory in the evening. AA-A stated staff tried not to let R1 go into other residents rooms but she did anyway and staff would direct her back out. AA-A stated she was aware of altercations between R1 and other residents and was told to keep an eye on them. AA-A stated R2 used to come out of her room, but recently she had been more depressed and did not really want to do much. AA-A stated R2 had been sleeping more since the incidents with R1 and said R2 did not feel safe in the common areas. AA-A stated R2 had told her she was scared of R1.

At 10:41 a.m. NA-A stated R1 was usually "pretty good" during the day and stated R1's behaviors started in the afternoon when she began walking and roaming. NA-A stated R1 would go into other peoples rooms and staff tried to catch her but were not always able to. NA-A stated some of the residents were scared of R1. Sometimes R1 was redirectable and sometimes not. NA-A stated she did not work with R2 very much but said she had heard she did not come out of her room very often, and more so lately.

At 10:40 a.m. registered nurse (RN)-A stated R1 got active around 3:30 p.m. to 4:00 p.m. RN-A stated they tried to have someone in the common areas and a wanderguard had been placed to alert staff if R1 was headed toward R2's room.

At 1:15 p.m. NA-B stated lately R2 had been more depressed and down and wanted to stay in her room. NA-B stated R2 had been getting up earlier but said R2 "definitely has wanted to stay

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in her room and was sleeping later, more depressed and down since some of the things with [R1] had taken place." NA-B further stated R2 was afraid of R1. Most of the altercations occurred during the evening and night shifts and they did not have the extra help like they did during the day when the director of nursing (DON), administrator, MDS nurse and social services staff were there.

On 11/19/20, at 1:06 p.m. AA-B stated R1 displayed wandering behaviors and stated the behaviors seemed directed mostly toward R2. AA-B stated R2 had been more withdrawn lately and would sometimes go to an activity if another resident she spent time with went but stated lately even if the other resident went to activities R2 would not always go. AA-B stated when she invited R2 to activities, R2 would say she wanted to stay in her room and sometimes would say she was afraid of R1 and did not want to be around her. AA-B stated when R1 was around R2 was hesitant and said, "It makes me sad."

R3's annual MDS dated 11/4/20, indicated she was severely cognitively impaired and required extensive assistance from two staff for activities of daily living. R3's care plan dated 11/16/20, indicated diagnosis of psychosis and depression and identified a history of abuse. The care plan directed staff to assess behavioral symptoms and monitor response to medication.

R3's Resident Progress Note dated 11/8/20, at 5:47 p.m. indicated R3 had a potential for bruising as another resident (R1) had grabbed her left wrist with one hand and mid arm area with the other and shook R3's arm for a short period before staff intervened. R3 had been sitting at the

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dining room table waiting for her meal to be served.

An incident Report Summary dated 11/8/20, indicated R1 grabbed R3 with two hands and shook R3 "vigorously" out of frustration when attempting to grab one of the glasses at the dining table. An Investigation Report dated 11/13/20, indicated on 11/8/20, R1 was trying to grab R3's table placements just before supper was served. After being re-directed several times, R1 got up again and grabbed R3's glass. R3 attempted to take the glass back at which time R1 grabbed R3's left arm with two hands and began shaking the arm out of frustration. R1 had been set up to eat outside the dining room for less stimulation. The facility was looking for alternate placement for R1 due to previous aggressive behaviors.

During observation on 11/18/20, at 2:37 p.m. R3 was seated in her wheel chair. A large bruise was covering R3's left hand and another bruise was visible on her left forearm.

On 11/19/20, at 3:06 p.m. NA-C and NA-D confirmed the bruises on R3's left hand and arm were a result of the altercation with R1. NA-C stated R1 was very "active" mid afternoon and after supper. NA-C stated staff try to re-direct R1 but she would go right back. NA-C stated when everyone else goes home (referring to management), it was really busy and stated it was just four staff members. NA-C and NA-D stated they did not feel like there was adequate staff in the evening to supervise R1.

R4's quarterly MDS dated 11/3/20, indicated he was severely cognitively impaired and was

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independent with activities of daily living. R4's care plan dated 11/16/20, identified psychosis and agitation and indicated he displayed behaviors including exit seeking, hollering, pushing and swearing at others. The care plan directed staff to provide a quiet environment free from background noises and distractions.

R4's Resident Progress Note dated 9/27/20, at 4:05 p.m. indicated R4 had been involved in an altercation with R1 in his room. Both residents were elbowing/pushing each other with their arms.

An Incident Report Summary dated 9/27/20, indicated staff heard yelling coming from R4' s room. Staff went to see what was happening and found R4 and R1 fighting over a magazine in R4's room. Staff observed R4 and R1 hitting each other in the arms with their elbows. An Investigation Report dated 9/30/20, indicated interventions to prevent further occurrence was to provide R1 with snacks as a redirection method.

9/28/20, Resident Progress Note indicated staff heard screams coming out of his room when they were walking by. Staff noted a female resident whom R4 had had an altercation with coming out of his room.

During interview on 11/18/20, at 11:42 a.m. the DON stated R1 was a newer resident and staff were trying to increase activities to keep her from getting bored. The DON stated R1 was non-verbal. Regarding the altercations between R1 and R2, the DON stated when R1 went down the hall exit seeking she would reach the doors and could not get out and would get frustrated. The DON said the first room R1 would see was

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R2' s room and stated R2 was more alert and would start screaming. The DON stated there had been a couple of altercations between R1 and R2 but stated there had been about four total altercations between R1 and other residents. The DON stated the facility was looking for alternate placement and said the physician had recommended a geriatric psychiatric unit but they were not currently taking patients and another facility had denied her. The facility had also talked about discharging R1 home with home health services or sending her to the emergency department until they could find placement. They currently had interventions in place that included a wanderguard and medication management. The DON stated R2's family member was currently looking for alternate placement for R2 because she was frustrated with the situation. The DON stated she had spoken to R2 about R1 on two occasions and she had been "okay." The DON stated R2 had not "directly" stated she was afraid of R1 but said she did not remember what R2 had told her.

At 1:22 p.m. the social services designee (SSD) stated R1 was non-verbal so she was unable to give feed back related to activity engagement. The SSD stated R1 was not interactive with other residents and liked to be by herself and wander. The SSD stated R1 had a couple of altercations with other residents and she had completed the investigations but did not think she was working when any of the altercations occurred. The SSD stated R2 had concerns about wandering residents including R1. She stated following the incidents a staff member would usually sit with R2 and console her and activity staff were asked to spend more one to one time with her. The SSD stated the facility had tried to set up "talk therapy"

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but family had declined. She said staff tried to check in with her and tried to keep R1 away from her. The SSD stated she had not asked R2 about being afraid of R1 since the last altercation. In regard to how the facility was protecting the other residents from R1, the SSD stated there had been a conversation about alternate placement in a place that could better meet her needs but in the short term they had set up a rummage room and tried to make sure her needs were being met.

On 11/19/20, at 1:20 p.m. RN-B and the SSD were interviewed. RN-B stated R1 admitted to the facility in July 2020, and there had been a decrease in her medications in September due to low blood pressures. After the medication decrease the staff started seeing more wandering and exit seeking behaviors. RN-B stated R1 was going into other rooms and escalated from that point. RN-B stated the last time a comprehensive assessment was completed for R1 was her admission assessment in July of 2020, and since then she had not been part of any conversation regarding an analysis of R1's behaviors. RN-B stated she had been present during one of the altercations between R1 and R2 and stated R2 was very upset. RN-B stated R2 still got upset when she saw R1 and said she recalled who R1 was and that she had been in her room. RN-B stated R2 was still leery of R1 going into her room. RN-B stated she had shown R2 another room and R2 had expressed she may like it but still asked if R1 was going to remain at the facility. RN-B stated she could not recall any team conversations related to R2's concerns about R1 or the increased signs of depression exhibited by R2. The SSD stated she tried to look at what was driving R1 outside her basic needs and that is

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how they ended up with the rummage room but stated R1 did not initiate use of the rummage room herself and staff had to bring her there. Further, staff really thought the altercations with other residents were related to the exit door and she liked to go into other residents rooms.

During interview on 11/18/20, at approximately 1:45 p.m. the administrator stated typically the person who witnessed an altercation between residents was the person who would report to the state agency and then the SSD would completed the investigation. The administrator stated staff would discuss the incidents in morning huddles and during interdisciplinary team (IDT) meetings. The incidents between R1 and R2 occurred and IDT felt it was related to R1 exit seeking. It seemed like the incidents occurred in the evening and R1 was more ambulatory in the evenings and became more active and wandered. The activity staff were trying to prevent R1 from wandering without purpose. The administrator stated the altercation with R3 happened in the dining room when R1 was "messing with" R3's cups and R3 became frustrated. She stated during the p.m. shift someone should be keeping an eye on R1 but no formal plan for supervision had been implemented. The administrator stated she had talked with R2 after the second altercation with R1 and said R2 told her she wanted to get out of the facility and that she was afraid of R1. The administrator stated activity staff had attempted more activities with R2.

A facility policy titled Riverview Care Center: Abuse Prevention Plan dated 8/5/2020, identified physical abuse to include; hitting, slapping, pinching and kicking. The policy indicated facility leadership assessed the needs of the residents in

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F 600	Continued From page 15 the facility to be able to identify concerns in order to prevent potential abuse. The policy indicated upon admission and periodically after that, each resident would have a safety and vulnerability assessment completed to identify potential vulnerabilities such as cognitive, physical, psychosocial and communication concerns with vulnerabilities with interventions included in the care plan. The policy indicated designated facility personnel began investigating immediately, a root cause analysis completed and information given to administration. The policy further indicated procedures must be in place to provide residents with a safe protected environment during the investigation.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 8, 2020

Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, MN 56716

Re: Event ID: 23DZ11

Dear Administrator:

The above facility survey was completed on November 19, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/17/20, through 11/19/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. 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		

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

Electronically Signed | 12/18/20

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5251030C; however, a licensing order was not issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		