Electronically Submitted
May 17, 2019

Administrator
Centennial Gardens For Nursing & Rehabilitation
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: Project Number H5289085C

Dear Administrator:

On May 4, 2019, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 4, 2019, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

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 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 July 23, 2019.

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).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 23, 2019 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 23, 2019 (42 CFR 488.417 (b)).

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.

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 $10,483; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 4, 2019. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician</u>

of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Centennial Gardens For Nursing & Rehabilitation is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 4, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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:

Eva Loch, Unit Supervisor
Metro D Survey Team

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 November 4, 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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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: 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.

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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@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
	245289	A. BUILDING _____ B. WING _____	C 05/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

(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 5/2/19 to 5/4/19, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F600. The immediate jeopardy began on 4/27/19, when R1 was hospitalized and found to have engaged in sexual intercourse while residing in the facility. The administrator was informed of the immediate jeopardy on 5/2/19 at 5:00 p.m. The immediate jeopardy was removed on 5/4/19, at 9:12 a.m. In addition, an extended survey was conducted by the Minnesota Department of Health on 5/3/19. The following complaint was found to be substantiated: H5289085C Deficiency issued at F Tag F600. 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	F 000		
F 600 SS=J	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	F 600		5/28/19

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

Electronically Signed | 05/23/2019

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 600	Continued From page 1 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- §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 interview and document review, the facility failed to implement procedures for supervision of cognitively impaired residents residing in the facility to ensure sexual abuse does not occur for 1 of 2 residents (R1) reviewed for sexual abuse. In addition the facility failed to complete a thorough investigation following an alleged incident of sexual relations between two residents residing in the facility. The facility failed to ensure the whereabouts of R1 who was cognitively impaired and had been observed outside the facility with R2 on at least two occasions resulting in the placement of a wander guard device. The immediate jeopardy began on 4/27/19, when R1 was hospitalized following an incident in which staff realized she was not in her room and she was found in a male resident's (R2) room. It was confirmed R1 had engaged in sexual intercourse with R2, but due to cognitive deficits is unable to give consent for sexual relations. The facility failed to thoroughly investigate the circumstances related to the incident. The adminstrator was informed of the immediate jeopardy on 5/2/19, at 5:00 p.m. While the immediate jeopardy was removed on 5/4/19, at 9:12 a.m., non-compliance remained at the lower scope and severity of a G.	F 600	It is the policy and procedure of Centennial Gardens to ensure safety of our residents and that resident incidents are thoroughly investigated. R1 was transferred to the local hospital and did not return. R2 remains at the facility and currently continues to receive 15-minute checks. These 15-minute checks are audited daily by the nurse manager and/or designee for compliance. R1 was also educated on safe consensual resident relationships and this intervention was added to R1's vulnerable adult care plan on 5/7/19. Facility residents were education on the consensual relationship policy on May 2 and 3, 2019 Facility staff were also in-serviced on this same policy and procedure May 2 and 3, 2019 All existing and newly admitted residents will have a vulnerability assessment completed upon admission and our consensual resident relationship policy will be reviewed during the admission agreement process. Residents who are cognitively impaired will have their care plan updated to indicate resident inability	

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F 600	Continued From page 2 R1's admission Minimum Data Set (MDS) dated 4/12/19, identified a cognitive assessment had not been completed due to R1 being rarely/never understood. The staff assessment for cognition indicated severe impairment. The MDS indicated R1 required assist of one staff for all activities of daily living (ADL)'s. R1's care plan dated 4/17/19, identified cognitive impairment, impaired safety awareness and amnesiac behaviors and identified a communication deficit related to receptive/expressive aphasia (loss of ability to understand or express speech) and weak or absent voice. The care plan directed staff to monitor R1's whereabouts every 30 minutes and document wandering behavior along with the placement of a wanderguard device. The care plan further identified R1 as a vulnerable adult and indicated a safety risk and potential for abuse related to her current medical condition. The care plan directed staff to ensure she was safe around others who may take advantage of her confusion. R2's quarterly MDS dated 3/6/19, indicated a cognitive assessment was not completed. The MDS further indicated R2 was independent with all ADL's. A facility assessment titled BIMS (brief interview for mental status) dated 3/7/19, identified a staff assessment that revealed no memory problem and indicated R2 was independent in making decision regarding tasks of daily life. R2's care plan dated 3/5/19, indicated he was independent with activities of daily living including dressing, transfers and ambulation. The care plan identified R2 as a vulnerable adult with diagnosis	F 600	to make consensual relationship agreements. Audits on vulnerability assessment completion, care plan development and review of the policy upon admission will begin May 28, 2019 4x a week for 4 weeks, then monthly x 2 months to ensure compliance. Any deviations to this plan will be brought to the QAPI committee for review and recommendation.	

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F 600	Continued From page 3	F 600		

including alcohol use/dependence and directed staff to monitor for signs of abuse/neglect.

A facility Progress Note dated 4/26/19, indicated, R2 was spoken to by writer about not taking other residents outside. R2 stated he would no longer do so.

A facility Progress Note dated 4/27/19, indicated at 11:20 p.m. staff informed writer R1 was not in her room and was not in her bathroom. While doing a search of other rooms on the unit staff approached R2's room. R2 started yelling at staff and asked them to get out of his room. The nurse went to R2's room and knocked at which time R2 opened his door a little and stood behind it. Staff noted R2 was not wearing a shirt but did not pay attention to what he was wearing on his bottom. When asked if he had seen R1, R2 answered no. When staff told R2 they needed to check his room, he told them he was naked and staff could not go in. Staff told R2 to put some clothes on so staff could enter his room. R2 went into his room for "awhile" so staff again knocked on his door. R2 opened the door and was dressed, appeared he was going to leave the room and pointed to R1 who was now coming out of R2's side of the room without any shoes or socks. When R2 was asked why he denied knowing where R1 was, he replied, "we were sleeping." R1 was sent to the hospital for evaluation.

A Progress Note dated 4/29/19, indicated the health unit coordinator (HUC) stated she saw R2 outside the front door sitting with R1, after R2 stated on Friday (4/26/19), at 2:00 p.m. he would not do that anymore. HUC stated this was on 4/26/19, around 5:00 p.m.

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F 600	Continued From page 4	F 600		

During interview on 5/2/19. at 1:11 p.m. social worker (SW)- A stated when R1 admitted to the facility a care conference was held with her daughter and stated R1's daughter was working on getting power of attorney. SW-A stated R1's daughter felt she was not able to make her own decisions, was cognitively at a teenage level and could not always be understood. SW-A stated when she spoke to R1 she would often just have a blank stare and did not have a good memory. Regarding the events that occurred on 4/27/19, SW-A stated her understanding of the events were as follows: R1 was out in a common area of the unit crying, another resident (R2) asked what was wrong and when he went to walk away, R1 asked where he was going. R2 invited R1 to watch television in his room. R2 stated he sat in the chair and R1 was on the bed. R1 fell asleep and R2 did not want to wake her. SW-A stated R1 was found in R2's bed with no incontinent brief on and R2 had no shirt on. In regard to R2, SW-A stated he was interviewable and appeared very helpful but stated he had made some comments to her that had caught her off guard. SW-A stated R2 had made comments to her such as telling her she had a nice figure and asked her if she stayed there all the time. SW-A further stated she knew R2 to be a heavy drinker and stated recently she was assisting him and he was not making sense, had slurred speech and was wobbling in his chair.

-During interview at 1:22 p.m. registered nurse (RN)-A stated she had received a call in the middle of the night on 4/27/19, that R1 was not in her room. RN-A stated according to notes staff had checked on her at 11:30 p.m. and she was not in her room. RN-A stated staff did a room search to locate her and when they knocked on

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F 600	Continued From page 5	F 600		

R2's room he would not let staff in. RN-A stated when staff told R2 they needed to do a room search R2 yelled that R1 was not in there so staff went to get the nurse who told R2 he had to let staff in his room. RN-A stated when staff entered the room, R1 was coming from R2's side of the room and when staff asked R2 why R1 was in his room, he stated they were just sleeping. RN-A stated she had spoken to R1's family member (FM)-A after the incident and FM-A told her there were positive signs R1 had had sexual intercourse. RN-A stated she had not questioned R2 at any time but stated she had done an investigation on her floor. RN-A stated she had asked everyone if between the hours of 10:00 p.m. and 12:00 a.m. if they had heard anyone yelling for help, distressful or yelling and screaming. RN-A stated no one in the rooms next to R2 heard anything. RN-A stated a meeting had taken place on the unit in which the administrator had explained to residents that it was okay to engage in a sexual relationship as long as both parties were consenting and able to make that decision. In regard to R1's ability to consent, RN-A stated, "It's hard to know for sure." RN-A stated R2 was placed on 15 minute checks on 4/27/19, and stated it was to continue until the administrator told them it was no longer needed. Upon reviewing the documentation titled, Wandering Observation 15 Minute Checks, there were times when the sheet was not filled out and other times when the sheet indicated R2 was downstairs on the first floor. RN-A stated, "I don't believe anyone was checking on him when he was off the unit."

A review of facility documents titled, Wandering Observation 15 Minute Checks identified the following:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6 4/27/19, 1:30 a.m. to 8:00 a.m. R2's whereabouts were not accounted for. 4/27/19, 12:00 p.m. to 1:00 p.m. R2 was downstairs in the first floor dining room. R2 resided on the third floor of the facility. 4/27/19, 5:00 p.m. to 10:30 p.m. R2 was downstairs on first floor. 4/28/19, 11:00 a.m. to 1:15 p.m. R2 was downstairs on the first floor and again from 5:45 p.m. to 7:00 p.m. 4/28/19, 5:00 p.m. to 5:45 pm. R2 was out for a walk, then on the first floor until 6:30 p.m. During interview on 5/2/19, at 2:27 p.m. the administrator stated he had spoken to R2 following the incident. The administrator stated R2 said he did not have any sexual relationship with R2 and that R2 told him R1 was in his room watching television, fell asleep and the next thing he knew staff was knocking on the door. The administrator stated when he asked R2 about the semen that was found on R1, R2 stated it was not him. The administrator stated he told R2 it was okay to have a relationship with another resident but he was responsible for making sure the other resident was capable of making that decision. The administrator stated R2 was placed on 15 minute checks and stated he believed staff were following up on the checks. He further stated staff had gotten together with the most competent residents and went through the same thing he had with R2 about ensuring consent. When asked about documention of the 30 minute checks R1 was placed on, the administrator stated he would have to look into it. During interview on 5/2/19, at 3:19 p.m. HUC-A stated the other resident referred to in the	F 600		

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	245289	A. BUILDING _____ B. WING _____	C 05/04/2019

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progress notes in which R2 was outside the facility was R1.

During interview on 5/2/19, at 4:19 p.m. the director of nursing (DON) stated the licensed nurses were responsible for completing the 15 minutes checks on R2 but stated the over all responsibility belonged to herself and the nurse manager. The DON further stated when R2 was not on the unit, whoever was responsible for that shift should have known where he was every 15 minutes. The DON stated prior to the incident that occurred with R1, she had never had a problem with R2. The DON stated she had interviewed R2 following the incident and R2 told her nothing had happened. When asked what time the last staff person had seen R1 prior to being found in R2's room, the DON stated she "thought" around 11:00 p.m. When asked if other residents were interviewed regarding unwanted attention or sexual advances by other residents, the DON stated, "no, we did not ask." She stated they had in-services with staff related to reporting.

At 4:33 p.m. the administrator stated he had spoke to the nurse manger on the unit about R1's 30 minute check. The administrator stated the 30 minute checks were never implemented.

During interview on 5/2/19, at 4:36 p.m. FM-A stated the hospital had performed an assessment of R1 that was positive for seminal fluid. FM-A stated she had concerns about R1's stay at the facility including R1 being put on a wander list, stating she found out after the fact. FM-A stated at one point SW-A had eluded to a resident hanging out around R1's room or seeking her out and after the incident occurred, RN-A had left her a message stating R2 had been asked not to

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have contact with R1. FM-A stated there were a lot of "gray areas and the facility is being very tight lipped." FM-A stated other than what the doctors at the hospital told her, she did not have a lot if information. In regard to R1, FM-A stated she would cry a lot since she admitted to the facility, especially when she and her sister would leave, but R1 could not articulate details of why she was sad. FM-A stated, "I doubt [R1] would have been able to say no or have the capacity to understand" and stated the only thing the doctors got out of her was she was scared and didn't know what to do.

During interview on 5/3/19, at 9:21 a.m. the medical director stated she was aware of the incident involving R1 and R2. The medical director stated she knew R1 was sent to the hospital and the hospital found seminal fluid. The medical director stated, "It's difficult, I don't think [R2] has much awareness, I don't know how much he is aware of the harm he has done." She further stated she knew R1 "certainly is not able to give consent."

A copy of the facility investigation was reviewed and contained the following:

An incident report form dated 4/27/19, indicated at 11:20 p.m., following a search for R1 who was not in her room, she was located in a male resident's (R2) room. The report contained the above mentioned progress note dated 4/27/19. The report further indicated R2 was placed on 15 minute checks. The report contained no further details.

An untitled piece of paper dated 4/29/19, at 10:20 (no indication of a.m. or p.m.) signed with initials:

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(Administrator and SW-A) interview with R2:

R2 talking with resident in tears asking if she was okay (referring to R1). R1 asked R2 where he was going and he said to watch television. R1 asked to go in his room. R1 sat on bed, R2 on chair. R2 took medications and passed out. When R2 woke up and saw R1 sleeping he did not want to wake her. Then police were there and took the bed sheet and took R1 away. In regard to the semen found on R1, R2 stated if did not happen, could not have happened. In regard to R1's incontinent brief, R2 stated not knowing why it was on the floor. Administrator let R2 know if another resident was not capable of making decisions he could be charged with rape. R2 understood. R2 was told it was never a good idea to have a woman in his room at midnight, R2 understood.

Untitled documents completed by staff with the following information:

Regarding the alleged sexual incident reported by staff on 4/26/19, involving another resident [R1].

- were you assigned to her?
- When did you se her last?
- Did she appear afraid? Guarded?
- Was evening care rendered to her? What time?
- staff signature.

4/26/19, Nursing assistant (NA-)-A wrote on a blank piece of paper: "I left [R1] in her room on her bed, changed her and left after my shift 11 p.m."

4/27/19, RN-B indicated she was assigned to R1, last saw her at 11:30 p.m. and she appeared

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calm. RN-B did not indicate where R1 was when seen at 11:30 p.m.

4/27/19, licensed practical nurse (LPN)-A indicated he was not assigned to R1, had last seen her at 11:30 p.m. and R1 did not appear afraid. LPN-A did not indicate where R1 was when last seen.

4/27/19, unidentified staff member indicated being assigned to R1, last saw her at 11:45 p.m. and R1 did not appear afraid. The unknown staff member did not indicate where R1 was last seen.

All of the staff interviewed indicated they last saw R1 between 11:00 p.m. and 11:45 p.m. even though Progress Notes indicated R1's whereabouts were unknown at 11:20 p.m. and a room search was conducted.

The investigation file further contained multiple statements from residents asking if they had heard or were awakened by anyone yelling for help as if they were in any kind of distress between 10:00 p.m. and 12:00 a.m. on 4/26/19, even though R1's care plan indicated she was rarely or ever able to be understood and had a weak or absent voice. All residents asked indicated they had not heard anything.

The immediate jeopardy was removed on 5/4/19, at 9:12 a.m. when the facility implemented and the following was verified: Assessment of vulnerable adults in the facility to determine their capacity to make decisions about relationships and monitoring of potential relationships, interviews with residents asking if anyone had approached them with sexual advances, development of a policy and procedure to identify

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F 600	Continued From page 11 residents who may begin a relationship in the facility, including; what to monitor and who to report to, staff education related to resident relationships and resident education related to potential relationships while residing in the facility. A facility policy titled Vulnerable Adult dated 5/10/18, indicated the primary goal of the faciltiy will be to ensure all residents are safe; all residents under the care of the facility are considered vulnerable. A vulnerable adult assessment and care plan will be completed upon admission and reviewed quarterly and annually. A facility policy titled Abuse Prevention Program undated, indicated our residents have the right to be free from abuse, neglect.... The policy defined sexual abuse as, but not limited to, sexual harassment, sexual coercion or sexual assault. Upon receiving reports of abuse an immediate investigation will be conducted.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 17, 2019

Administrator
Centennial Gardens For Nursing & Rehabilitation
3245 Vera Cruz Avenue North
Crystal, MN 55422

Re: State Nursing Home Licensing Orders - Complaint Number H5289085C

Dear Administrator:

A complaint investigation was completed on May 4, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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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 5/2/19 to 5/4/19, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are 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 The following complaint(s) was/were found to be substantiated: H5289085C Correction order(s) issued at 144.651 Subd. 14 1850 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of	21850		5/28/19

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21850	Continued From page 2 conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement procedures for supervision of cognitively impaired residents residing in the facility to ensure sexual abuse does not occur for 1 of 2 residents (R1) reviewed for sexual abuse. In addition the facility failed to complete a thorough investigation following an alleged incident of sexual relations between two residents residing in the facility. The facility failed to ensure the whereabouts of R1 who was cognitively impaired and had been observed outside the facility with R2 on at least two occasions resulting in the placement of a wander guard device. The immediate jeopardy began on 4/27/19, when R1 was hospitalized following an incident in which staff realized she was not in her room and she was found in a male resident's (R2) room. It was confirmed R1 had engaged in sexual intercourse with R2, but due to cognitive deficits is unable to give consent for sexual relations. The facility failed to thoroughly investigate the circumstances related to the incident. The adminstrator was informed of the immediate jeopardy on 5/2/19, at 5:00 p.m. While the immediate jeopardy was removed on 5/4/19, at 9:12 a.m., non-compliance remained at the lower scope and severity of a G.	21850	Completed	

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21850	Continued From page 3 R1's admission Minimum Data Set (MDS) dated 4/12/19, identified a cognitive assessment had not been completed due to R1 being rarely/never understood. The staff assessment for cognition indicated severe impairment. The MDS indicated R1 required assist of one staff for all activities of daily living (ADL)'s. R1's care plan dated 4/17/19, identified cognitive impairment, impaired safety awareness and amnesiac behaviors and identified a communication deficit related to receptive/expressive aphasia (loss of ability to understand or express speech) and weak or absent voice. The care plan directed staff to monitor R1's whereabouts every 30 minutes and document wandering behavior along with the placement of a wanderguard device. The care plan further identified R1 as a vulnerable adult and indicated a safety risk and potential for abuse related to her current medical condition. The care plan directed staff to ensure she was safe around others who may take advantage of her confusion. R2's quarterly MDS dated 3/6/19, indicated a cognitive assessment was not completed. The MDS further indicated R2 was independent with all ADL's. A facility assessment titled BIMS (brief interview for mental status) dated 3/7/19, identified a staff assessment that revealed no memory problem and indicated R2 was independent in making decision regarding tasks of daily life. R2's care plan dated 3/5/19, indicated he was independent with activities of daily living including dressing, transfers and ambulation. The care plan identified R2 as a vulnerable adult with diagnosis including alcohol use/dependence and directed	21850		

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21850	Continued From page 4 staff to monitor for signs of abuse/neglect. A facility Progress Note dated 4/26/19, indicated, R2 was spoken to by writer about not taking other residents outside. R2 stated he would no longer do so. A facility Progress Note dated 4/27/19, indicated at 11:20 p.m. staff informed writer R1 was not in her room and was not in her bathroom. While doing a search of other rooms on the unit staff approached R2's room. R2 started yelling at staff and asked them to get out of his room. The nurse went to R2's room and knocked at which time R2 opened his door a little and stood behind it. Staff noted R2 was not wearing a shirt but did not pay attention to what he was wearing on his bottom. When asked if he had seen R1, R2 answered no. When staff told R2 they needed to check his room, he told them he was naked and staff could not go in. Staff told R2 to put some clothes on so staff could enter his room. R2 went into his room for "awhile" so staff again knocked on his door. R2 opened the door and was dressed, appeared he was going to leave the room and pointed to R1 who was now coming out of R2's side of the room without any shoes or socks. When R2 was asked why he denied knowing where R1 was, he replied, "we were sleeping." R1 was sent to the hospital for evaluation. A Progress Note dated 4/29/19, indicated the health unit coordinator (HUC) stated she saw R2 outside the front door sitting with R1, after R2 stated on Friday (4/26/19), at 2:00 p.m. he would not do that anymore. HUC stated this was on 4/26/19, around 5:00 p.m. During interview on 5/2/19. at 1:11 p.m. social worker (SW)- A stated when R1 admitted to the	21850		

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facility a care conference was held with her daughter and stated R1's daughter was working on getting power of attorney. SW-A stated R1's daughter felt she was not able to make her own decisions, was cognitively at a teenage level and could not always be understood. SW-A stated when she spoke to R1 she would often just have a blank stare and did not have a good memory. Regarding the events that occurred on 4/27/19, SW-A stated her understanding of the events were as follows: R1 was out in a common area of the unit crying, another resident (R2) asked what was wrong and when he went to walk away, R1 asked where he was going. R2 invited R1 to watch television in his room. R2 stated he sat in the chair and R1 was on the bed. R1 fell asleep and R2 did not want to wake her. SW-A stated R1 was found in R2's bed with no incontinent brief on and R2 had no shirt on. In regard to R2, SW-A stated he was interviewable and appeared very helpful but stated he had made some comments to her that had caught her off guard. SW-A stated R2 had made comments to her such as telling her she had a nice figure and asked her if she stayed there all the time. SW-A further stated she knew R2 to be a heavy drinker and stated recently she was assisting him and he was not making sense, had slurred speech and was wobbling in his chair.

-During interview at 1:22 p.m. registered nurse (RN)-A stated she had received a call in the middle of the night on 4/27/19, that R1 was not in her room. RN-A stated according to notes staff had checked on her at 11:30 p.m. and she was not in her room. RN-A stated staff did a room search to locate her and when they knocked on R2's room he would not let staff in. RN-A stated when staff told R2 they needed to do a room search R2 yelled that R1 was not in there so staff

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went to get the nurse who told R2 he had to let staff in his room. RN-A stated when staff entered the room, R1 was coming from R2's side of the room and when staff asked R2 why R1 was in his room, he stated they were just sleeping. RN-A stated she had spoken to R1's family member (FM)-A after the incident and FM-A told her there were positive signs R1 had had sexual intercourse. RN-A stated she had not questioned R2 at any time but stated she had done an investigation on her floor. RN-A stated she had asked everyone if between the hours of 10:00 p.m. and 12:00 a.m. if they had heard anyone yelling for help, distressful or yelling and screaming. RN-A stated no one in the rooms next to R2 heard anything. RN-A stated a meeting had taken place on the unit in which the administrator had explained to residents that it was okay to engage in a sexual relationship as long as both parties were consenting and able to make that decision. In regard to R1's ability to consent, RN-A stated, "It's hard to know for sure." RN-A stated R2 was placed on 15 minute checks on 4/27/19, and stated it was to continue until the administrator told them it was no longer needed. Upon reviewing the documentation titled, Wandering Observation 15 Minute Checks, there were times when the sheet was not filled out and other times when the sheet indicated R2 was downstairs on the first floor. RN-A stated, "I don't believe anyone was checking on him when he was off the unit."

A review of facility documents titled, Wandering Observation 15 Minute Checks identified the following:

4/27/19, 1:30 a.m. to 8:00 a.m. R2's whereabouts were not accounted for.
4/27/19, 12:00 p.m. to 1:00 p.m. R2 was

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downstairs in the first floor dining room. R2 resided on the third floor of the facility.
4/27/19, 5:00 p.m. to 10:30 p.m. R2 was downstairs on first floor.
4/28/19, 11:00 a.m. to 1:15 p.m. R2 was downstairs on the first floor and again from 5:45 p.m. to 7:00 p.m.
4/28/19, 5:00 p.m. to 5:45 pm. R2 was out for a walk, then on the first floor until 6:30 p.m.

During interview on 5/2/19, at 2:27 p.m. the administrator stated he had spoken to R2 following the incident. The administrator stated R2 said he did not have any sexual relationship with R2 and that R2 told him R1 was in his room watching television, fell asleep and the next thing he knew staff was knocking on the door. The administrator stated when he asked R2 about the semen that was found on R1, R2 stated it was not him. The administrator stated he told R2 it was okay to have a relationship with another resident but he was responsible for making sure the other resident was capable of making that decision. The administrator stated R2 was placed on 15 minute checks and stated he believed staff were following up on the checks. He further stated staff had gotten together with the most competent residents and went through the same thing he had with R2 about ensuring consent. When asked about documention of the 30 minute checks R1 was placed on, the administrator stated he would have to look into it.

During interview on 5/2/19, at 3:19 p.m. HUC-A stated the other resident referred to in the progress notes in which R2 was outside the facility was R1.

During interview on 5/2/19, at 4:19 p.m. the director of nursing (DON) stated the licensed

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nurses were responsible for completing the 15 minutes checks on R2 but stated the over all responsibility belonged to herself and the nurse manager. The DON further stated when R2 was not on the unit, whoever was responsible for that shift should have known where he was every 15 minutes. The DON stated prior to the incident that occurred with R1, she had never had a problem with R2. The DON stated she had interviewed R2 following the incident and R2 told her nothing had happened. When asked what time the last staff person had seen R1 prior to being found in R2's room, the DON stated she "thought" around 11:00 p.m. When asked if other residents were interviewed regarding unwanted attention or sexual advances by other residents, the DON stated, "no, we did not ask." She stated they had in-services with staff related to reporting.

At 4:33 p.m. the administrator stated he had spoke to the nurse manger on the unit about R1's 30 minute check. The administrator stated the 30 minute checks were never implemented.

During interview on 5/2/19, at 4:36 p.m. FM-A stated the hospital had performed an assessment of R1 that was positive for seminal fluid. FM-A stated she had concerns about R1's stay at the facility including R1 being put on a wander list, stating she found out after the fact. FM-A stated at one point SW-A had eluded to a resident hanging out around R1's room or seeking her out and after the incident occurred, RN-A had left her a message stating R2 had been asked not to have contact with R1. FM-A stated there were a lot of "gray areas and the facility is being very tight lipped." FM-A stated other than what the doctors at the hospital told her, she did not have a lot if information. In regard to R1, FM-A stated she would cry a lot since she admitted to the

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facility, especially when she and her sister would leave, but R1 could not articulate details of why she was sad. FM-A stated, "I doubt [R1] would have been able to say no or have the capacity to understand" and stated the only thing the doctors got out of her was she was scared and didn't know what to do.

During interview on 5/3/19, at 9:21 a.m. the medical director stated she was aware of the incident involving R1 and R2. The medical director stated she knew R1 was sent to the hospital and the hospital found seminal fluid. The medical director stated, "It's difficult, I don't think [R2] has much awareness, I don't know how much he is aware of the harm he has done." She further stated she knew R1 "certainly is not able to give consent."

A copy of the facility investigation was reviewed and contained the following:

An incident report form dated 4/27/19, indicated at 11:20 p.m., following a search for R1 who was not in her room, she was located in a male resident's (R2) room. The report contained the above mentioned progress note dated 4/27/19. The report further indicated R2 was placed on 15 minute checks. The report contained no further details.

An untitled piece of paper dated 4/29/19, at 10:20 (no indication of a.m. or p.m.) signed with initials: (Administrator and SW-A) interview with R2:

R2 talking with resident in tears asking if she was okay (referring to R1). R1 asked R2 where he was going and he said to watch television. R1 asked to go in his room. R1 sat on bed, R2 on chair. R2 took medications and passed out.

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When R2 woke up and saw R1 sleeping he did not want to wake her. Then police were there and took the bed sheet and took R1 away. In regard to the semen found on R1, R2 stated if did not happen, could not have happened. In regard to R1's incontinent brief, R2 stated not knowing why it was on the floor. Administrator let R2 know if another resident was not capable of making decisions he could be charged with rape. R2 understood. R2 was told it was never a good idea to have a woman in his room at midnight, R2 understood.

Untitled documents completed by staff with the following information:

Regarding the alleged sexual incident reported by staff on 4/26/19, involving another resident [R1].

- were you assigned to her?
- When did you se her last?
- Did she appear afraid? Guarded?
- Was evening care rendered to her? What time?
- staff signature.

4/26/19, Nursing assistant (NA-)-A wrote on a blank piece of paper: "I left [R1] in her room on her bed, changed her and left after my shift 11 p.m."

4/27/19, RN-B indicated she was assigned to R1, last saw her at 11:30 p.m. and she appeared calm. RN-B did not indicate where R1 was when seen at 11:30 p.m.

4/27/19, licensed practical nurse (LPN)-A indicated he was not assigned to R1, had last seen her at 11:30 p.m. and R1 did not appear afraid. LPN-A did not indicate where R1 was when last seen.

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21850	Continued From page 11 4/27/19, unidentified staff member indicated being assigned to R1, last saw her at 11:45 p.m. and R1 did not appear afraid. The unknown staff member did not indicate where R1 was last seen. All of the staff interviewed indicated they last saw R1 between 11:00 p.m. and 11:45 p.m. even though Progress Notes indicated R1's whereabouts were unknown at 11:20 p.m. and a room search was conducted. The investigation file further contained multiple statements from residents asking if they had heard or were awakened by anyone yelling for help as if they were in any kind of distress between 10:00 p.m. and 12:00 a.m. on 4/26/19, even though R1's care plan indicated she was rarely or ever able to be understood and had a weak or absent voice. All residents asked indicated they had not heard anything. The immediate jeopardy was removed on 5/4/19, at 9:12 a.m. when the facility implemented and the following was verified: Assessment of vulnerable adults in the facility to determine their capacity to make decisions about relationships and monitoring of potential relationships, interviews with residents asking if anyone had approached them with sexual advances, development of a policy and procedure to identify residents who may begin a relationship in the facility, including; what to monitor and who to report to, staff education related to resident relationships and resident education related to potential relationships while residing in the facility. A facility policy titled Vulnerable Adult dated 5/10/18, indicated the primary goal of the faciltiy will be to ensure all residents are safe; all	21850		

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21850	Continued From page 12 residents under the care of the facility are considered vulnerable. A vulnerable adult assessment and care plan will be completed upon admission and reviewed quarterly and annually. A facility policy titled Abuse Prevention Program undated, indicated our residents have the right to be free from abuse, neglect.... The policy defined sexual abuse as, but not limited to, sexual harassment, sexual coercion or sexual assault. Upon receiving reports of abuse an immediate investigation will be conducted. SUGGESTED METHOD OF CORRECTION: The Administrator, Director of Nursing and/or designee(s) could assure policies are reviewed, revised and implemented for supervision of vulnerable, cognitively impaired, residents residing in the facility, by developing a system wide process to keep residents safe. TIME PERIOD FOR CORRECTION: One (1) day.	21850		