Electronically delivered
May 15, 2019

Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

RE: Project Number H5458019C

Dear Administrator:

On May 2, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the May 2, 2019 abbreviated standard survey the Minnesota Department of Health, completed an investigation of complaint number H5458019C.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is June 11, 2019.

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.

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

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

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by August 2, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 2, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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,

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
	245458	A. BUILDING _____ B. WING _____	C 05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH VIRGINIA, MN 55792**

(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 5/1/19, and 5/2/19, 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: H5458019C, deficiency issued at F610. 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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		6/10/19

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

Electronically Signed | 05/20/2019

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 610	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a thorough investigation to assure residents were safe, following a complaint of potential abuse, for 1 of 3 residents (R1) investigated for abuse. Findings include: R1's annual Minimum Data Set (MDS) dated 4/3/19, included diagnoses of hemiplegia (paralysis of one side of body), and chronic pain. The MDS identified R1 was cognitively intact, required supervision and set up for eating, required extensive to total assistance for all other activities of daily living (ADLs) and had obvious or likely cavity or broken natural teeth. R1's dental Care Area Assessment (CAA) dated 4/6/19, identified R1 had his own natural teeth with several missing, and required extensive assistance with oral hygiene. R1 denied need for dental exam at that time. R1's care plan dated 4/6/19, identified R1 required extensive to total assistance with hygiene, and directed staff to set up and assist R1 with the use of an electric toothbrush after breakfast and dinner.	F 610	1. R1 was immediately assessed and he was seen by a dentist on 5/1/19 with no further follow up required. He denied discomfort throughout. 2. We have interviewed all residents who are cognitively able to respond to questions, asking “Have you ever felt that staff was rough while providing care?” and other customer service questions including “ Are you familiar with your rights?” “Do you know how to report maltreatement or/and concerns?”. Resident rights were reviewed and follow up on answers as necessary. 3. Our policy has been updated to reflect more detail in the investigative process including interviewing other residents when an allegation pertains to staff. Education has been provided to social workers and licensed clinical staff regarding the process of a thorough investigation. 4. Interviews will be conducted utilizing the abuse questionarre on 20% of residents weekly x4. Then monthly at resident council ongoing. Abuse will be reported to the Administrator and appropriate authorities immediately and	

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F 610	Continued From page 2 On 5/1/19, at 9:54 a.m. R1 was interviewed stated he was going to the dentist at 1:10 p.m. that day. R1 stated a few days ago licensed practical nurse (LPN)-A had given his medication with either a plastic spoon or tongue depressor, and was rough, which had chipped his tooth. R1 pointed to the tooth next to his left front tooth which had a chip in the center. R1 stated he did not mention it to LPN-A when it happened, but when a staff member asked about his broken teeth a few days later, he mentioned the incident to them. R1 stated LPN-A had never been rough with him before, but had been rough with him that day. The facility incident report dated 4/24/19, identified R1 had chipped left incisor. The report included R1 indicated LPN-A chipped the tooth while giving R1 medications, and that LPN-A was rough. The report further indicated LPN-A was removed from the schedule pending investigation. The facility investigative report dated 4/29/19, identified some inconsistencies were found, but confirmed R1 had a chipped tooth. The report further identified R1 felt LPN-A was rough and did not like LPN-A. The report indicated LPN-A would receive sensitivity training, would not provide care for R1, and would be monitored by a registered nurse for customer satisfaction. An untitled, undated form identified interviews that were completed included the clinical manager, register nurse (RN)-A, family member (FM)-A, nursing assistant (NA)-D, LPN-A, and NA-E. The interviews failed to include questions	F 610	varriances will be brought to QAPI at least quarterly.	

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F 610	Continued From page 3	F 610		

regarding the possibility of other rough treatment of residents by LPN-A or others. The list of interviews also failed to include other staff or resident interviews to assure resident safety.

On 5/1/19, at 10:10 a.m. RN-A was interviewed and stated she had heard about R1's tooth during report from the night shift LPN. RN-A stated she then spoke with R1, who told her LPN-A was rough and had pushed really hard with a spoon when she gave him the medications which chipped his tooth. RN-A immediately informed the director of nursing (DON), and the DON instructed her to ask more questions. Licensed social worker (LSW)-B and RN-A interviewed R1 about the incident. R1 had told them LPN-A had been rough in the past, but denied pain, and stated the incident happened about a week before. RN-A stated NA-D told her she was aware of the chipped tooth a few days prior, but R1 did not want anything done. NA-D had forgotten to report the chipped tooth, and R1 had not mentioned the potential abuse.

On 5/1/19, at 10:34 a.m. the DON was interviewed and stated RN-A had informed her of LPN-A's rough treatment and chipped tooth. R1 had informed a FM-A that someone had chipped the tooth during a meal, and informed RN-A it was during medication administration. LPN-A had not been back on the schedule yet, but was scheduled to work that night. LPN-A informed her R1 did not like her. Others had told her LPN-A, "was a little rough around the edges." The DON had planned to allow LPN-A to work the night shift, then in the morning would do some coaching with LPN-A. The plan was to educate, get to the root cause, and coach LPN-A

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F 610	Continued From page 4	F 610		

about the chipped tooth and rough treatment. The DON was unaware if any other residents had concerns about LPN-A being rough, as no other residents were interviewed.

On 5/1/19, at 12:54 p.m. the DON confirmed she had not interviewed any other residents regarding alleged rough treatment from LPN-A. The DON confirmed she had not interviewed any other staff regarding allegations of rough treatment from LPN-A. The DON stated she had spoken to both LSW-A and LSW-B, but no other staff interviews were documented. The plan of correction would be for her to monitor LPN-A, now do some additional interviews of staff and residents, and ensure LPN-A was being supervised by an RN while working. However, on the night shift LPN-A worked on one floor, and an RN on a different floor.

On 5/1/19, at 1:41 p.m. the administrator was interviewed and stated she was informed of the incident by the DON after RN-A reported it. The administrator stated she had been informed of the investigation, and understood LPN-A stated it was an accident.

On 5/1/19, at 1:45 p.m. the DON reviewed the facility policy of Just Culture and reviewed how she used the algorithm to decide on what action she would take. The DON indicated LPN-A was instructed to complete sensitivity training, which was the Hand in Hand training program. LPN-A had completed the first two modules, but would complete the rest of the modules tomorrow morning.

On 5/1/19, at 3:54 p.m. the DON stated LPN-A

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F 610	Continued From page 5	F 610		

was not going to work the night shift. She had spoken with the human resource department, and was advised not to have LPN-A work that night. The new plan was for LPN-A to come in tomorrow morning, and the DON would meet with LPN-A, and then LPN-A would finish the last three modules for the Hand in Hand sensitivity training.

On 5/2/19, at 8:36 a.m. LPN-A was interviewed and stated she had given R1 his medications in the dining room with a plastic spoon or tongue depressor. LPN-A denied being rough with R1, and stated she had placed the medications in his opened mouth with the spoon. R1 had not informed her of the chipped tooth. R1 had not grimaced, cried out, or exhibited signs of pain. LPN-A stated she had been scheduled to work the night shift last night, but had received a call yesterday not to come in until the morning. LPN-A denied any previous involvements with abuse or neglect allegations, and denied to having received any disciplinary actions in the past.

The facility provided a form titled CMS Hand in Hand; A Training Series For Nursing Homes Toolkit dated 5/1/19. The mission was to provide nursing homes with a high quality training program that emphasis person-centered care of persons with dementia and the prevention of abuse.

The facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property reviewed 1/24/19, directed reports of abuse would be investigated promptly and thoroughly. The policy further directed resident statements,

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F 610	Continued From page 6 resident roommate statements (if applicable), staff and witness statements, and observation of resident and staff behaviors would be completed. The policy further directed the safety, security and support of the resident and other residents with the potential to be affected would be provided. The facility policy Guidelines For Employee And Organizational Accountability Within A Just Culture undated, directed the purpose was for a consistent approach for managing risk and accountability. The policy further directed the responsibilities of management with consultation of human resources was for counseling, coaching, remedial action and disciplinary action. The policy directed management may need to conduct an investigation pursuant to the Just Culture algorithm with the assistance of human resources or other Just Culture champions when staff do not comply with the rules, fail to achieve outcomes or cause harm.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 15, 2019

Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

Re: State Nursing Home Licensing Orders - Complaint Number H5458019C

Dear Administrator:

A complaint investigation was completed on May 2, 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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,

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

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	00603	A. BUILDING: _____ B. WING _____	C 05/02/2019

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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 5/1/19, and 5/2/19, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found not to be in compliance with the MN state licensure. The following complaint(s) were found to be substantiated:	2 000		

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2 000	Continued From page 1 H5458019C was found not to be in compliance at the time of the survey. 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		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.	22000		6/10/19

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	00603	A. BUILDING: _____ B. WING _____	C 05/02/2019

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ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 55792

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22000	Continued From page 2 (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a thorough investigation to assure residents were safe, following a complaint of potential abuse, for 1 of 3 residents (R1) investigated for abuse. Findings include: R1's annual Minimum Data Set (MDS) dated 4/3/19, included diagnoses of hemiplegia (paralysis of one side of body), and chronic pain. The MDS identified R1 was cognitively intact, required supervision and set up for eating, required extensive to total assistance for all other activities of daily living (ADLs) and had obvious	22000	1. R1 was immediately assessed and he was seen by a dentist on 5/1/19 with no further follow up required. He denied discomfort throughout. 2. We have interviewed all residents who are cognitively able to respond to questions, asking “Have you ever felt that staff was rough while providing care?” and other customer service questions including “ Are you familiar with your rights?” “Do you know how to report maltreatement or/and concerns?”. Resident rights were reviewed and follow up on answers as necessary. 3. Our policy has been updated to reflect	

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22000	Continued From page 3 or likely cavity or broken natural teeth. R1's dental Care Area Assessment (CAA) dated 4/6/19, identified R1 had his own natural teeth with several missing, and required extensive assistance with oral hygiene. R1 denied need for dental exam at that time. R1's care plan dated 4/6/19, identified R1 required extensive to total assistance with hygiene, and directed staff to set up and assist R1 with the use of an electric toothbrush after breakfast and dinner. On 5/1/19, at 9:54 a.m. R1 was interviewed stated he was going to the dentist at 1:10 p.m. that day. R1 stated a few days ago licensed practical nurse (LPN)-A had given his medication with either a plastic spoon or tongue depressor, and was rough, which had chipped his tooth. R1 pointed to the tooth next to his left front tooth which had a chip in the center. R1 stated he did not mention it to LPN-A when it happened, but when a staff member asked about his broken teeth a few days later, he mentioned the incident to them. R1 stated LPN-A had never been rough with him before, but had been rough with him that day. The facility incident report dated 4/24/19, identified R1 had chipped left incisor. The report included R1 indicated LPN-A chipped the tooth while giving R1 medications, and that LPN-A was rough. The report further indicated LPN-A was removed from the schedule pending investigation. The facility investigative report dated 4/29/19, identified some inconsistencies were found, but	22000	more detail in the investigative process including interviewing other residents when an allegation pertains to staff. Education has been provided to social workers and licensed clinical staff regarding the process of a thorough investigation. 4. Interviews will be conducted utilizing the abuse questionarre on 20% of residents weekly x4. Then monthly at resident council ongoing. Abuse will be reported to the Administrator and appropriate authorities immediately and varriances will be brought to QAPI at least quarterly.	

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22000	Continued From page 4 confirmed R1 had a chipped tooth. The report further identified R1 felt LPN-A was rough and did not like LPN-A. The report indicated LPN-A would receive sensitivity training, would not provide care for R1, and would be monitored by a registered nurse for customer satisfaction. An untitled, undated form identified interviews that were completed included the clinical manager, register nurse (RN)-A, family member (FM)-A, nursing assistant (NA)-D, LPN-A, and NA-E. The interviews failed to include questions regarding the possibility of other rough treatment of residents by LPN-A or others. The list of interviews also failed to include other staff or resident interviews to assure resident safety. On 5/1/19, at 10:10 a.m. RN-A was interviewed and stated she had heard about R1's tooth during report from the night shift LPN. RN-A stated she then spoke with R1, who told her LPN-A was rough and had pushed really hard with a spoon when she gave him the medications which chipped his tooth. RN-A immediately informed the director of nursing (DON), and the DON instructed her to ask more questions. Licensed social worker (LSW)-B and RN-A interviewed R1 about the incident. R1 had told them LPN-A had been rough in the past, but denied pain, and stated the incident happened about a week before. RN-A stated NA-D told her she was aware of the chipped tooth a few days prior, but R1 did not want anything done. NA-D had forgotten to report the chipped tooth, and R1 had not mentioned the potential abuse. On 5/1/19, at 10:34 a.m. the DON was interviewed and stated RN-A had informed her of LPN-A's rough treatment and chipped tooth. R1	22000		

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22000	Continued From page 5 had informed a FM-A that someone had chipped the tooth during a meal, and informed RN-A it was during medication administration. LPN-A had not been back on the schedule yet, but was scheduled to work that night. LPN-A informed her R1 did not like her. Others had told her LPN-A, "was a little rough around the edges." The DON had planned to allow LPN-A to work the night shift, then in the morning would do some coaching with LPN-A. The plan was to educate, get to the root cause, and coach LPN-A about the chipped tooth and rough treatment. The DON was unaware if any other residents had concerns about LPN-A being rough, as no other residents were interviewed. On 5/1/19, at 12:54 p.m. the DON confirmed she had not interviewed any other residents regarding alleged rough treatment from LPN-A. The DON confirmed she had not interviewed any other staff regarding allegations of rough treatment from LPN-A. The DON stated she had spoken to both LSW-A and LSW-B, but no other staff interviews were documented. The plan of correction would be for her to monitor LPN-A, now do some additional interviews of staff and residents, and ensure LPN-A was being supervised by an RN while working. However, on the night shift LPN-A worked on one floor, and an RN on a different floor. On 5/1/19, at 1:41 p.m. the administrator was interviewed and stated she was informed of the incident by the DON after RN-A reported it. The administrator stated she had been informed of the investigation, and understood LPN-A stated it was an accident. On 5/1/19, at 1:45 p.m. the DON reviewed the	22000		

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22000	Continued From page 6 facility policy of Just Culture and reviewed how she used the algorithm to decide on what action she would take. The DON indicated LPN-A was instructed to complete sensitivity training, which was the Hand in Hand training program. LPN-A had completed the first two modules, but would complete the rest of the modules tomorrow morning. On 5/1/19, at 3:54 p.m. the DON stated LPN-A was not going to work the night shift. She had spoken with the human resource department, and was advised not to have LPN-A work that night. The new plan was for LPN-A to come in tomorrow morning, and the DON would meet with LPN-A, and then LPN-A would finish the last three modules for the Hand in Hand sensitivity training. On 5/2/19, at 8:36 a.m. LPN-A was interviewed and stated she had given R1 his medications in the dining room with a plastic spoon or tongue depressor. LPN-A denied being rough with R1, and stated she had placed the medications in his opened mouth with the spoon. R1 had not informed her of the chipped tooth. R1 had not grimaced, cried out, or exhibited signs of pain. LPN-A stated she had been scheduled to work the night shift last night, but had received a call yesterday not to come in until the morning. LPN-A denied any previous involvements with abuse or neglect allegations, and denied to having received any disciplinary actions in the past. The facility provided a form titled CMS Hand in Hand; A Training Series For Nursing Homes Toolkit dated 5/1/19. The mission was to provide nursing homes with a high quality training	22000		

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22000	Continued From page 7 program that emphasis person-centered care of persons with dementia and the prevention of abuse. The facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property reviewed 1/24/19, directed reports of abuse would be investigated promptly and thoroughly. The policy further directed resident statements, resident roommate statements (if applicable), staff and witness statements, and observation of resident and staff behaviors would be completed. The policy further directed the safety, security and support of the resident and other residents with the potential to be affected would be provided. The facility policy Guidelines For Employee And Organizational Accountability Within A Just Culture undated, directed the purpose was for a consistent approach for managing risk and accountability. The policy further directed the responsibilities of management with consultation of human resources was for counseling, coaching, remedial action and disciplinary action. The policy directed management may need to conduct an investigation pursuant to the Just Culture algorithm with the assistance of human resources or other Just Culture champions when staff do not comply with the rules, fail to achieve outcomes or cause harm. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop policies and procedures regarding reporting and investigating all alleged abuse/neglect/mistreatment. The administrator or designee could educate all staff on those policies and procedures. The administrator or designee	22000		

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22000	Continued From page 8 could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		