Electronically Submitted
August 6, 2020

Administrator
Elim Home
701 First Street
Princeton, MN 55371

RE: CCN: 245494
Cycle Start Date: July 20, 2020

Dear Administrator:

On July 20, 2020, survey was completed at your facility by the Minnesota Department 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.

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 a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 18, 2020, the situation of immediate jeopardy to potential health and safety cited at F0600 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 20, 2020.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 20, 2020 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 20, 2020 (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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §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. 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 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, Elim Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 20, 2020. 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), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356

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 January 20, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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: 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	C 07/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	**701 FIRST STREET PRINCETON, MN 55371**

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E 000	Initial Comments On 7/16/20 to 7/20/20, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health (MDH) to determine compliance with Emergency Preparedness regulations §483.73(b)(6). Elim Home was found to be in compliance with the requirement. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledged recepit of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/16/20 to 7/20/20, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct complaint investigation(s). Elim Home was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. In addition, a COVID-19 Focused Infection Control survey was conducted at the facility by MDH to determine compliance with §483.80 Infection Control. Elim Home was found not to be in compliance. The survey resulted in an immediate jeopardy (IJ), and substandard quality of care, at F600 when a credible allegation of abuse voiced by resident(s) and staff had not been reported to the required parties, acted upon, investigated and protection provided to resident(s) at risk in the locked memory care unit to ensure they remained	F 000		

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

Electronically Signed | 08/17/2020

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F 000	Continued From page 1	F 000		

free of abuse. The administrator (via telephone), director of nursing (DON) and registered nurse (RN)-A were notified of the IJ on 7/17/20, at 4:26 p.m. The IJ was removed on 7/18/20; however, non-compliance remained with potential for more than minimal harm which is not immediate jeopardy at a pattern level (Level E). In addition, an extended survey was conducted on 7/20/20.

The following complaint(s) were found to be substantiated:

H5494042C; with no deficiencies issued. However, unrelated non-compliance was identified and cited at F610.

H5494043C; with no deficiencies issued.

H5494044C; with no deficiencies issued. However, unrelated non-compliance was identified and cited at F636 and F744.

H5494045C; with no deficiencies issued.

H5494046C; with deficiencies issued at F684 and F689.

H5494048C; with no deficiencies issued.

H5494049C; with no deficiencies issued.

H5494050C; with deficiencies issued at F600, F609 and F610.

The following complaint(s) were found unsubstantiated:

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F 000	Continued From page 2 H5494047C 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 substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §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 ensure allegations of abuse were	F 600	Regarding cited resident: • Resident #10- Investigation into	8/25/20

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F 600	Continued From page 3 appropriately reported to the required person(s) and agencies, investigated and adequate protection provided to ensure freedom from abuse for 3 of 6 residents (R9, R10, R11) whose allegations were reviewed. These findings constituted an immediate jeopardy (IJ) situation which had potential to affect 16 of 16 residents who resided on the Rum River Place secured memory unit at the time of the survey as TMA-A continued to work despite allegations of abuse towards residents. The IJ began on 6/27/20, when an employee (trained medication aide (TMA)-A) was witnessed with her hands grasped around R9's wrists while voicing to the resident, "You're not going to hit me again. We're not doing this tonight!" Following the incident, no formal re-education was completed for TMA-A and no subsequent audits or monitoring of her care was implemented to ensure residents remained free of abuse. On approximately 7/1/20, a second incident was witnessed and reported to the unit manager regarding TMA-A where she had been witnessed yelling and being "mean" to a different resident in the locked memory care unit. This allegation was not acted upon, reported or investigated and TMA-A continued to work unsupervised with no protection plan(s) being implemented to ensure all residents on the locked unit remained safe and free of abuse by TMA-A. The administrator (via telephone), director of nursing (DON) and registered nurse (RN)-A were notified of the IJ on 7/17/20, at 4:26 p.m. The IJ was removed on 7/18/ 20, at 5:25 p.m. when the facility successfully implemented a removal plan; however, non-compliance remained at a pattern scope with potential for more than minimal harm which is not immediate jeopardy (Level E).	F 600	findings initiated on 7/17/20. • Staff involved in the reported incident were suspended pending completion of the investigation. • TMA-A was terminated. • RN-A was removed from leadership position. • Resident #9 and #11 assessed for signs of psychosocial distress or fear. with no ongoing distress noted. Actions taken to identify other potential residents having similar occurrences: • QAPI committee convened to perform Root Cause Analysis of F600 and associated tags. Committee members in attendance: Administrator, DON, Director of Corporate Compliance, Director of Operations, Clinical Directors of SNF Services and Human Resources. • Conducted interviews with those residents residing within the dementia unit and who were able to verbalize concerns. • All cognitively intact residents interviewed regarding customer service experience and any concerns of abuse/neglect. Measures put in place to ensure deficient practice does not recur: • Reviewed Vulnerable Adult policy. • Staff training on the revised VA policy with a focus on the requirement to report witnessed or potential occurrences of abuse or neglect. • Weekly auditing throughout the building-2 audits per unit, per week X 2 weeks then 1 audit per unit per week X 2	

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F 600	Continued From page 4 Findings include: A submitted initial State agency (SA) report, dated 6/27/20, identified an allegation of physical abuse regarding R9 which read, "Conduct intended to produce pain/injury or rough handling." The report identified on 6/27/20, at 7:40 p.m. an incident happened in the hallway of the locked memory care unit which included, "[R9] was attempting to walk another resident ... staff intervened and [R9] was upset about being distracted and attempted to hit [TMA-A]. [TMA-A] grabbed the resident's wrist and stated, 'you need to stay out here.' Another staff reported that [TMA-A] said, 'We are not doing this tonight.'" The report identified the supervisor was notified and TMA-A was sent home until further investigation could be completed. A corresponding undated Verification of Investigation (VOI) report identified the facility completed an investigation into the allegation submitted to the SA on 6/27/20. The report outlined, "[R9] was attempting to walk another resident and verbalized intent to assist with toileting, staff intervened and [R9] was upset about being distracted and attempted to hit [TMA-A]. [TMA-A] grabbed [R9's] wrist and stated, 'you need to stay out here.' Another staff reported that [TMA-A] said, 'we are not doing this tonight." The report identified the supervisor was notified of the incident and TMA-A was sent home pending further investigation. R9 expressed feeling safe at the nursing home; however, when questioned if she was afraid of anyone at the nursing home, R9 was recorded as, " ... she shrugged her shoulders and said 'I just ignore them' and started chuckling." The administrator,	F 600	weeks which includes both resident interview and staff care observations (see POC binder for questions and observations). Results will be tabulated and reviewed for necessary action. • Results of these audits will be reviewed until substantial compliance is achieved and they will make the decision if further monitoring/audits are recommended.	

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F 600	Continued From page 5	F 600		

DON, social worker, physician and SA were all notified of the incident, and a series of witness statements were listed which included statements from multiple staff members including nursing assistant (NA)-A, NA-B, and TMA-A. NA-A's recorded interview described TMA-A as being witnessed "with a grip on [R9's] wrist and she was pulling her aggressively, and [R9] almost tripped." NA-A instructed TMA-A to be gentle to which TMA-A responded, "I am so done," as she threw her hands up in the air. NA-A described R9 immediately following the incident as, "She seemed scared." Further, the report concluded with an, "Investigation Summary," which outlined TMA-A had intercepted R9's attempt to strike her which " ... was interpreted as rough behavior on [TMA-A's] part by another staff member who intervened ..." The DON then re-educated TMA-A on customer service and professional communication.

The submitted SA investigation (5-Day Report), dated 7/3/20, was reviewed and identified R9's care plan was reviewed and followed, along with the facility policy which was listed as, " ... followed," and no changes were made after the incident occurred. The facility's completed investigation was outlined which reflected the VOI detail(s) in large, and an additional form was attached which demonstrated TMA-A had been provided with a verbal disciplinary action along with education on customer service and professional behavior. The form was signed by the DON on 6/29/20, and TMA-A was listed as having verbally acknowledged the form through a telephone call on 6/29/20. The space provided for the administrator to sign the form was left blank and unsigned or dated.

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F 600	Continued From page 6	F 600		

There was no evidence in the completed VOI or subsequent SA investigation demonstrating TMA-A had been formally re-educated on the facility's abuse policies and procedures including what constitutes abuse or any education on understanding behavioral symptoms of residents which could increase the risk of abuse and how to respond.

A provided resident listing, dated 7/16/20, identified a total of 16 residents resided on the Rum River Unit (locked memory care unit) including R9, R10 and R11.

R9's annual Minimum Data Set (MDS), dated 4/8/20, identified R9 had severe cognitive impairment; however, demonstrated no delusions or physical behavioral symptoms (i.e. hitting, kicking). On 7/17/20, at 9:50 a.m. R9 was interviewed in her room. R9 voiced she was not sure how long she had lived at the nursing home and just replied, "No," when asked if she had any concerns with staff treatment or her care.

On 7/17/20, at 10:52 a.m. nursing assistant (NA) -A was interviewed and stated she had worked with TMA-A on the evening of 6/27/20, when she stayed late to help put residents to bed. NA-A explained R9 was a resident who frequently wandered into a specific resident' room to use their bathroom and needed to be re-directed; however, at approximately 7:30 p.m. NA-A stated she had come out of a resident room and witnessed TMA-A's hands grasped and "squeezing" around R9's wrists as R9 seemed to struggle to free herself from TMA-A's grasp by shaking and pulling back. NA-A stated she immediately told TMA-A to let go of R9, however, TMA-A did not and continued to grasp R9's

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wrists, so NA-A quickly tossed the linens in her hands into a resident room and returned to R9 and TMA-A who remained in the hallway. TMA-A then released R9's wrists and yelled, "I'm so done" as she walked away from R9. NA-A proceeded to help R9 to use a bathroom on the opposite end of the unit and R9 was upset immediately following the incident, R9 even voiced she thought TMA-A had left bruising on her. NA-A completed R9's cares and then reported the allegation and incident to the working supervisor who subsequently reported it to the DON. NA-A voiced TMA-A was not allowed to complete her shift the night of the incident involving R9 as she was sent home; however, expressed significant concern as TMA-A had subsequently returned to work on the dementia unit on an unsupervised basis. NA-A expressed following TMA-A's return to work, a second incident had happened where TMA-A had potentially abused residents. NA-A stated she knew R11 had expressed concern to a homemaker (HMK)-A that she (R11) had observed TMA-A to place her hands on and shout at another resident (R10) in the memory care unit just a few days after the incident with R9 on 6/27/20. NA-A stated, to her knowledge, HMK-A and R11 did report these concerns to the registered nurse unit manager (RN)-B; however, added she was concerned as, "I don't know if they even looked into that much." NA-A stated she had known TMA-A to be "very aggressive" at times with residents with her tone of voice; however, had never witnessed her be physically abusive with residents until the incident on 6/27/20, adding, "I saw what I saw." Further, NA-A reiterated she was concerned TMA-A would continue to potentially abuse residents on the locked memory care unit as TMA-A continued to

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work, as of that day (7/17/20), on an unsupervised basis for "eight hours of the night [shift]."

R11's quarterly MDS, dated 6/15/20, identified R11 had severe cognitive impairment; however, demonstrated no delusions or hallucinations. When interviewed on 7/17/20, at 11:25 a.m. R11 stated she had lived at the nursing home for approximately four years as she needed help with her diabetes management. R11 stated she had no concerns about the way staff treated her; however, expressed she had recently seen a female staff member (TMA-A) abusing a resident in a wheelchair. R11 described TMA-A's actions as "grabbing her and pushing her" while holding her arms and wrists up to the surveyor. R11 described TMA-A as "loud" while she helped people and voiced she, herself, had never had an issue with TMA-A; however, added "the other people [residents] they're not talking [due to cognitive impairment]." R11 reiterated the incident she had observed between a resident and TMA-A as something she felt was "not nice" and "not right." R11 expressed she told a staff member about the incident; however, was not able to remember who, but added she reported TMA-A to them as someone who was "mean" and screams at people.

On 7/17/20, at 1:47 p.m. HMK-A was interviewed and verified R11 had reported a concern to her approximately "two weeks ago" which alleged TMA-A had "grabbed another resident." HMK-A described R11's reported concern to her as TMA-A was "yelling at this other resident and took her arm and pulled her." HMK-A stated she told R11 they needed to go and report the incident to the unit manager and described R11 as "upset by

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it [the incident]," as she was talking very fast while reporting it and "almost manic and not breathing between words." HMK-A explained R11 was fearful of retaliation by TMA-A and told HMK-A she "[didn't] want her [TMA-A] mad at me." HMK-A verified the incident witnessed and reported to her by R11 was reported to the unit manager (RN-B); however, she was unsure of specific follow-up which had been completed as there had already been "a different incident reported" pertaining to TMA-A around the "same time frame." Further, HMK-A stated she had never personally witnessed TMA-A to be physically abusive to a resident; however, had witnessed her to become impatient with residents before and seem "a little frustrated" while providing direction or cares to them.

On 7/17/20, at 2:02 p.m. TMA-A was interviewed and stated her current employment was "full time" at the nursing home. TMA-A started working at the nursing home in January 2020, and typically worked during the overnight hours. TMA-A described the incident from 6/27/20, which involved R9. TMA-A had stepped in front of R9 to re-direct her which caused R9 to get upset and attempt to hit out at TMA-A. TMA-A verified she then grabbed R9's arm to stop her and said, "You're not going to hit me. We're not doing this today." At the same time, another staff member had walked out of a room and observed the interaction while directing TMA-A, "Oh my God, you need to be nice." TMA-A stated she didn't feel she had grabbed R9 with a closed hand around her wrists, however, said it was more like she grabbed her arm and "pushed it down." TMA-A stated she could not recall anymore specifics from the event; however, added since it had happened she had been spoken to by the

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DON on things "like mannerisms and professionalism." TMA-A added she thought the DON had also discussed with her the various acts, including placing hands on a resident like the incident on 6/27/20 outlined, could constitute abuse and would not be acceptable. TMA-A denied any further incidents with residents on the memory care unit and voiced she continued to work alone on the memory care unit on the overnight shift. TMA-A stated she was not aware of being placed on any formal buddy-systems for cares or monitoring of the care she provided, adding she had just worked last on 7/15/20, and was scheduled to work again in the coming days.

When interviewed on 7/17/20, at 2:29 p.m. registered nurse (RN)-D stated they typically work on the overnight shift and verified working full-time with TMA-A adding, "She's my TMA." RN-D acknowledged they were aware of an incident involving R9 and TMA-A which had occurred in the past weeks; however, did not witness it or recall specifics. RN-D stated they had not been instructed or directed to do any monitoring or observing of TMA-A's cares or demeanor while at work. RN-D verified TMA-A is left alone for her job "most of the time" while working as they were often on a different unit adding, "Most days she works alone."

On 7/17/20, at 2:33 p.m. RN-B and the DON were interviewed and expressed the facility's administrator was off campus on vacation at the time of the survey. The DON described her understanding of the incident involving TMA-A and R9 on 6/27/20, as a situation where R9 was trying to walk another resident in the hallway and TMA-A attempted to intervene which caused R9 to react. TMA-A then placed "her hands around

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her [R9] wrists" to prevent her from striking out. NA-A had walked out of a room in the middle of the incident and observed the "grabbing of the wrists" and so she reported it to the supervisor, TMA-A was sent home, and the incident report was filed to the SA. The DON stated she was unsure of the exact manner or specifics regarding TMA-A's hands and the subsequent grip she had around R9's wrists (i.e. open hand pushing down on the wrists or a closed fist around the wrists) as she did not question it at the time with the staff members; however, voiced such actions could constitute abuse depending on how the resident is grabbed and how aggressive the overall situation was at the moment. The DON explained they interviewed TMA-A regarding the 6/27/20, incident as part of their overall investigation, and TMA-A felt her actions were not abusive. The DON verbalized she told TMA-A her actions could be perceived as abusive and then had a "lengthy conversation" with TMA-A on professionalism and customer service as a result of the incident on 6/27/20; however, she did not complete or assign her any formal Relias (computerized healthcare training) courses on abuse, vulnerable adult (VA) or dementia-related policies and procedures. The DON verified TMA-A returned to work on 7/1/20, on an unsupervised basis with no formal audits or monitoring of her care being completed or implemented. RN-B recalled R9 had voiced "being scared" immediately following the incident on 6/27/20. As part of the investigation, RN-B had attempted to interview other residents on the locked memory care unit she felt would be able to cognitively respond which included R11. RN-B stated R11 did not initially report any concerns about TMA-A; however, within a couple days following their discussion, R11 and HMK-A approached her and reported a second allegation

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of abuse involving TMA-A and a different resident (R10). RN-B stated she felt the initial discussion with R11, as part of the 6/27/20, incident follow-up, had planted a seed in R11's mind which caused her to report the second allegation as R11 had a history of paranoia. RN-B stated she could not recall specifics of the second allegation HMK-A and R11 had shared with her; however, recalled she had taken notes about it on a personal note-pad when the allegation was reported to her. An undated, untitled copy of the taken notes was provided. The notes identified TMA-A's name at the top along with various one-line sentences which included:

"Always pulling [R10] - come here,"

"Just happened a couple of days ago,"

"She's mean,"

"She's nice to me,"

"Yells-too aggressive. Threatens them," and,

"[R11] pulled [HMK-A's] arm to demo - quite agressively [sic]."

The interview continued and RN-B stated she would not consider R10 or R11 to be a credible historian (despite having selected R11 to interview as part of the 6/27/20 incident), but added things R11 had reported in the past seemed to "always [have] a basis of truth." When questioned how the second allegation was handled and investigated, RN-B stated she did not immediately report the allegation to the administrator or DON as she did not feel it was credible as "it's coming from [R11], that's why."

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RN-B stated she placed no formal monitoring of TMA-A's cares, nor did she complete any re-education with TMA-A as part of the second allegation and verified, as of 7/17/20, TMA-A remained working unsupervised on the night shift with the resident population on the Rum River Unit. The DON stated this was "the first time I am hearing of the second event [allegation]" and voiced, had she and the administrator been told of it, she would have reported it as an allegation of abuse and investigated it as such in accordance with their abuse prevention policy. RN-B and the DON expressed that, to their knowledge, the facility's administrator had no knowledge of the second allegation being reported to RN-B.

A provided Vulnerable Adult Report / Tracking Log, dated 10/17/19 to 7/16/20, identified all facility reported incidents (FRI) to the State agency. The listing lacked evidence R11's allegation of abuse pertaining to TMA-A was reported to the State agency.

TMA-A's undated training transcript identified TMA-A was hired at the nursing home on 2/20/20. A course named, "Abuse & Neglect Self-Paced," was listed as being completed on 2/20/20. A second course with the same name was listed which was not completed; however, listed a 'Due Date' of 7/31/20. There was no evidence on TMA-A's transcript or any other provided documentation demonstrating TMA-A had been formally re-educated on the definitions of abuse, nor subsequent strategies to handle behaviors from cognitively impaired residents after the allegation of abuse was reported and investigated, ending on 7/3/20. Further, there were several classes listed, including

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"Alzheimer's Disease and Related Disorders: Behavior Management," which had listed 'due dates' prior to 7/1/20; however, the classes were not completed and no completion date was identified. In addition, there was no evidence provided during the survey demonstrating TMA-A had been placed on any formal monitoring upon her return to work to ensure she completed therapeutic approaches for the residents and did not engage in potentially abusive behavior(s) towards them despite multiple allegations of abuse being reported pertaining to her.

A provided Schedule dated 7/1/20 to 7/31/20, identified TMA-A had worked from 6:45 p.m. to 7:15 a.m. on the following days: 7/1/20, 7/6/20, 7/7/20, 7/10/20, 7/11/20, 7/12/20, and 7/15/20. Further, the schedule outlined TMA-A continued to be scheduled for the same shift hours on 7/20/20, 7/21/20, 7/24/20 and 7/29/20.

The facility's Vulnerable Adult - MN policy, revised 10/31/19, identified all staff members must report suspected or alleged abuse immediately and added, "The administrator is responsible for the implementation of the policy." The policy outlined residents have a right to be free from verbal and physical abuse and all residents of the facility were considered vulnerable adults. The policy directed, "Each employee is responsible to report suspected/alleged violations of mistreatment ... immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury ...," and, "The Administrator will be notified immediately." The policy listed a series of sections which were meant to address and prevent allegations of abuse. A section labeled, "Prevention/Protection," identified all staff were

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F 600	Continued From page 15 trained to understand the facility' abuse prohibition plan along with identify inappropriate behaviors (i.e. rough handling, derogatory language) and added, "If a staff member at any time displays suspect or inappropriate behavior, the supervisor must intervene and take appropriate action." A section labeled, "Resident Protection During Investigation," was listed which directed to provide immediate safety of the resident(s) upon identification by completing actions which included, but were not limited to, removing the resident from the alleged perpetrator (AP) care or suspending them. Further, the policy directed all reports of suspected or alleged abuse would be " ... promptly and thoroughly investigated," which included collecting data around the incident, a physical examination of the resident(s) for signs of abuse and interviews with other residents and staff members. The policy directed to document the results of the investigation and log the incident on a facility Event Summary. The IJ which began on 6/27/20, was removed on 7/18/20, at 5:25 p.m. when the facility successfully implemented a removal plan which included removing the AP from resident care, reporting and beginning the investigation of R11's allegation in accordance with their facility's policy, and educating staff members on the reporting process to ensure all allegations made by residents were reported to the administrator and SA. On 7/18/20, from 4:14 p.m. to 5:13 p.m. interview(s) were completed with direct care and management staff to ensure these items had been successfully implemented.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		8/25/20

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F 609	Continued From page 16 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of potential physical abuse was reported to the administrator and State agency (SA) within two hours, as required, for 1 of 6 residents (R11) whose allegations were reviewed. Findings include:	F 609	Regarding cited resident: • Review of resident #11 care plan with updates made to reflect resident status and history of reporting incidents to staff on behalf of other residents. • Initiated an investigation regarding resident #10. Resident assessed for signs of psychological distress or fear.	

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F 609	Continued From page 17 R11's quarterly MDS, dated 6/15/20, identified R11 had severe cognitive impairment; however, demonstrated no delusions or hallucinations. When interviewed on 7/17/20, at 11:25 a.m. R11 stated she had lived at the nursing home for approximately four years as she needed help with her diabetes management. R11 stated she had no concerns about the way staff treated her; however, expressed she had recently seen a female staff member (TMA-A) abusing a resident in a wheelchair. R11 described TMA-A's actions as "grabbing her and pushing her" while holding her arms and wrists up to the surveyor. R11 described TMA-A as "loud" while she helped people and voiced she, herself, had never had an issue with TMA-A; however, added "the other people [residents] they're not talking [due to cognitive impairment]." R11 reiterated the incident she had observed between a resident and TMA-A as something she felt was "not nice" and "not right." R11 expressed she told a staff member about the incident; however, was not able to remember who, but added she reported TMA-A to them as someone who was "mean" and screams at people. On 7/17/20, at 1:47 p.m. HMK-A was interviewed and verified R11 had reported a concern to her approximately "two weeks ago" which alleged TMA-A had "grabbed another resident." HMK-A described R11's reported concern to her as TMA-A was "yelling at this other resident and took her arm and pulled her." HMK-A stated she told R11 they needed to go and report the incident to the unit manager and described R11 as "upset by it [the incident]," as she was talking very fast while reporting it and "almost manic and not breathing between words." HMK-A explained R11 was	F 609	• Staff involved in the reported incident suspended pending completion of the investigation. • RN-A was removed from leadership position. • TMA-A terminated from her position. Actions taken to identify other potential residents having similar occurrences: • QAPI committee convened to perform Root Cause Analysis of F609 and associated tags. Committee members in attendance: Administrator, DON, Director of Corporate Compliance, Director of Operations, Clinical Directors of SNF services and Human Resources. • Staff retraining on the Vulnerable Adult policy. • Staff interviews/audits initiated on 7/17/20 on Vulnerable Adult policy/reporting. • Conducted memory care resident interviews. Exceptions where residents were unable to engage in interview process documented. • All other residents interviewed regarding safety, security, and customer service. Measures put in place to ensure deficient practice does not recur: • Vulnerable Adult policy reviewed. • Staff training on the revised VA policy with a focus on the requirement to report witnessed or potential occurrences of abuse or neglect. • Conduct vulnerable adult reporting	

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F 609	Continued From page 18 fearful of retaliation by TMA-A and told HMK-A she "[didn't] want her [TMA-A] mad at me." HMK-A verified the incident witnessed and reported to her by R11 was reported to the unit manager (RN-B); however, she was unsure of specific follow-up which had been completed as there had already been "a different incident reported" pertaining to TMA-A around the "same time frame." A provided Vulnerable Adult Report / Tracking Log, dated 10/17/19 to 7/16/20, identified all facility reported incidents (FRI) to the State agency. The listing lacked evidence R11's allegation of abuse pertaining to TMA-A she voiced to RN-B had been reported. Further, R11's medical record lacked any evidence the allegation had been reported to the administrator and/or SA since being voiced to HMK-A and RN-B On 7/17/20, at 2:33 p.m. RN-B and the director of nursing (DON) were interviewed and expressed the facility' administrator was off campus on vacation at the time of the survey. RN-B explained she had interviewed R11 as part of a different allegation; however, within a couple days following their discussion, R11 and HMK-A approached her and reported a second allegation of abuse involving the same staff member and a different resident. RN-B stated she could not recall specifics of the second allegation HMK-A and R11 had shared with her; however, recalled she had taken notes about it on a personal note-pad when the allegation was reported to her. An undated, untitled copy of the taken notes was provided. The notes identified TMA-A's name at the top along with various one-line sentences which included:	F 609	interviews with a minimum of 90% of active staff. • Staff to complete Abuse/Neglect Relias training. • Audit all VA reports submitted after 7/20/20 to ensure submission in accordance with the VA policy and state/federal requirements. Effective implementation of actions will be monitored by: • QAPI committee will review audit results until substantial compliance is achieved and a decision is made regarding a time-period for further auditing/ monitoring.	

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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 609	Continued From page 19	F 609		

"Always pulling [R10] - come here,"

"Just happened a couple of days ago,"

"She's mean,"

"She's nice to me,"

"Yells-too aggressive. Threatens them," and,

"[R11] pulled [HMK-A's] arm to demo - quite agressively [sic]."

RN-B stated she would not consider R11 to be a credible historian, but added things R11 had reported in the past seemed to "always [have] a basis of truth." When questioned how the second allegation was handled and investigated, RN-B stated she did not immediately report the allegation to the administrator or DON as she didn't feel it was credible as "it's coming from [R11], that's why." The DON stated this was "the first time I am hearing of the second event [allegation]" and voiced, had she and the administrator been told of it, she would have reported it as an allegation of abuse in accordance with their abuse prevention policy. RN-B and the DON expressed that, to their knowledge, the facility' administrator had no knowledge of the second allegation being reported to RN-B.

The facility' Vulnerable Adult - MN policy, revised 10/31/19, identified all staff members must report suspected or alleged abuse immediately and added, "The administrator is responsible for the implementation of the policy." The policy outlined residents have a right to be free from verbal and

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	245494	A. BUILDING _____ B. WING _____	C 07/20/2020

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F 609	Continued From page 20 physical abuse and all residents of the facility were considered vulnerable adults. The policy directed, "Each employee is responsible to report suspected/alleged violations of mistreatment ... immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury ...," and, "The Administrator will be notified immediately."	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegation(s) of potential physical abuse and/or neglect were thoroughly investigated and addressed for 2 of 6 residents (R11, R6) whose allegations were reviewed. This had potential to affect 16 of 16 residents identified	F 610	Regarding cited resident: • Initiated investigations related to residents #6 (11/14/19) and #11 (7/17/20). • Staff involved in the reported incident were suspended pending completion of the investigation.	8/25/20

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F 610	Continued From page 21 to reside on the Rum River Unit (locked memory care unit). Findings include: A provided resident listing, dated 7/16/20, identified a total of 16 residents resided on the Rum River Unit (locked memory care unit) including R11. R11's quarterly MDS, dated 6/15/20, identified R11 had severe cognitive impairment; however, demonstrated no delusions or hallucinations. When interviewed on 7/17/20, at 11:25 a.m. R11 stated she had lived at the nursing home for approximately four years as she needed help with her diabetes management. R11 expressed she had recently seen a female staff member (TMA-A) abusing a resident in a wheelchair by "grabbing her and pushing her." R11 described TMA-A as "loud" while she helped people and voiced she, herself, had never had an issue with TMA-A; however, added "the other people [residents] they're not talking [due to cognitive impairment]." R11 reiterated the incident she had observed between a resident and TMA-A as something she felt was "not nice" and "not right." R11 expressed she told a staff member about the incident; however, was not able to remember who, but added she reported TMA-A to them as someone who was "mean" and screams at people. On 7/17/20, at 1:47 p.m. HMK-A was interviewed and verified R11 had reported a concern to her approximately "two weeks ago" which alleged TMA-A had "grabbed another resident." HMK-A described R11's reported concern to her as TMA-A was "yelling at this other resident and took	F 610	• TMA-A terminated (#11). • RN-A removed from leadership position (#11). Actions taken to identify other potential residents having similar occurrences: • The QAPI committee convened to conduct Root Cause Analysis of F610 and associated tags. Committee members in attendance: Administrator, DON, Director of Corporate Compliance, Director of Operations, Clinical Directors of SNF services and Human Resources. • Staff provided with the Vulnerable Adult policy and staff interviews initiated on Vulnerable Adult policy/reporting. • Audited vulnerable adult report log for OHFC allegation. Updated log template based off audit findings. • Ensure monitoring system is in place for any staff with allegations upon returning to work (see measure put in place – internal investigation work sheet template). Measures put in place to ensure deficient practice does not recur: • Vulnerable Adult policy reviewed on 07/17/20. • Staff retrained on updated policy. • VA investigative work sheet updated with area to include report related follow up action. • Conduct vulnerable adult reporting interviews with a threshold of 90% of the active staff. • Staff will complete the 2020	

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F 610	Continued From page 22 her arm and pulled her." HMK-A stated she told R11 they needed to go and report the incident to the unit manager and described R11 as "upset by it [the incident]," as she was talking very fast while reporting it and "almost manic and not breathing between words." HMK-A explained R11 was fearful of retaliation by TMA-A and told HMK-A she "[didn't] want her [TMA-A] mad at me." HMK-A verified the incident witnessed and reported to her by R11 was reported to the unit manager (RN-B); however, she was unsure of specific follow-up which had been completed as there had already been "a different incident reported" pertaining to TMA-A around the "same time frame." Further, HMK-A stated she had never personally witnessed TMA-A to be physically abusive to a resident; however, had witnessed her become impatient with residents before and seem "a little frustrated" while providing direction or cares to them. On 7/17/20, at 2:33 p.m. RN-B and the director of nursing (DON) were interviewed and expressed the facility' administrator was off campus on vacation at the time of the survey. RN-B explained she had interviewed R11 as part of a different allegation; however, within a couple days following their discussion, R11 and HMK-A approached her and reported a second allegation of abuse involving the same staff member and a different resident. RN-B stated she could not recall specifics of the second allegation HMK-A and R11 had shared with her; however, recalled she had taken notes about it on a personal note-pad when the allegation was reported to her. An undated, untitled copy of the taken notes was provided. The notes identified TMA-A's name at the top along with various one-line sentences which included:	F 610	Abuse/Neglect Relias training. • In person and by Zoom VA Reporting Training available to all staff through an external presenter. Effective implementation and continued compliance of corrective actions will be monitored on an ongoing basis at quarterly QAPI meetings: • Review current resident interviews and staff care audits to determine compliance. • Determine necessary action for further auditing/monitoring.	

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RN-B stated she would not consider R11 to be a credible historian, but added things R11 had reported in the past seemed to "always [have] a basis of truth." When questioned how the second allegation was handled and investigated, RN-B stated she did not immediately report the allegation to the administrator or DON as she didn't feel it was credible. The DON stated this was "the first time I am hearing of the second event [allegation]" and voiced, had she and the administrator been told of it, she would have investigated it as an allegation of abuse in accordance with their abuse prevention policy. RN-B and the DON expressed that, to their knowledge, the facility' administrator had no knowledge of the second allegation being reported to RN-B.

A provided Vulnerable Adult Report / Tracking Log, dated 10/17/19 to 7/16/20, identified all facility reported incidents (FRI) to the State agency. The listing lacked evidence R11's allegation of abuse pertaining to TMA-A she voiced to RN-B had been reported or investigated. Further, no documented evidence

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F 610	Continued From page 24	F 610		

was provided during the survey demonstrating it had been investigated.

A completed Nursing Home Incident Reporting - Incident Report Summary 33157, printed 7/16/20, identified the facility had submitted a report to the State agency (SA) on 11/14/19, involving R6. The report outlined an allegation of, "Emotional or Mental Abuse," and described an incident where it had been identified a nursing assistant (NA) was potentially transferring R6 inappropriately and not in accordance with her care plan. The NA was re-educated, however, it was alleged the NA went back into R6's room at a later date and voiced, "Thanks a lot. I might be losing my job because of you." This caused R6 to become upset and cry.

A corresponding undated Verification of Investigation (VOI) form identified the 11/14/19 incident involving the NA and R6. The report identified R6 was interviewed and expressed concern for "possibly costing [the NA] her job because she had told the [night] supervisor that [the NA] always transferred her in the 2 pt [point] lift by herself." The report identified the administrator and SA were notified of the allegation. A section labeled, "Witnesses ...," was provided which included interviews from another staff member and the NA involved. A section labeled, "Investigation Summary," identified the completed investigation timeline for the allegation along with a plan which included reviewing the StandUp Lift policy with the NA, providing immediate re-education to the NA and reviewing R6's care plan. However, the report and subsequent summary lacked any evidence other resident interviews were completed to help

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determine potential other allegations of neglect aside from R6; nor did it list any procedures or steps taken demonstrating the NA identified would be monitored or audited to ensure they were implementing care plans correctly to prevent harm or injury to residents.

A completed SA investigation (5-Day), dated 11/18/19, identified the investigation was submitted to the SA which outlined the facility' completed investigation along with the identical plan which was listed on the VOI Form. This completed investigation lacked any evidence other resident interviews were completed to help determine potential other allegations of neglect aside from R6; nor did it list any procedures or steps taken demonstrating the NA identified would be monitored or audited to ensure they were implementing care plans correctly to prevent harm or injury to residents.

R6's quarterly Minimum Data Set (MDS), dated 6/25/20, identified R6 had intact cognition and required extensive assistance for transfers. When interviewed on 7/16/20, at 3:07 p.m. R6 recalled the incident from 11/14/19, and denied being upset or fearful of injury while being cared for at the nursing home. R6 stated since the incident, staff had consistently been using two people to transfer her.

On 7/17/20, at 10:39 a.m. the director of nursing (DON) was interviewed regarding R6's allegation on 11/14/19. The DON acknowledged the lack of evidence in the investigation summary, and corresponding VOI Form, demonstrating if other residents had been interviewed; or if the NA was placed under any formal audits or monitoring upon the investigation completion to ensure care

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plans were being followed. The DON voiced she would speak to the unit manager and follow-up. A subsequent interview was held with the DON on 7/17/20, at 12:35 p.m. and she voiced investigation(s) typically included other resident interviews to help determine the scope of the allegation and see if additional allegations are identified. The DON expressed these interviews are done using an audit tool, and provided some completed "Customer Service Audits" for a total of three other residents which were used as part of their investigation in to R6's allegation. However, all of these provided audits were dated 11/22/19 (four days after the investigation was completed and submitted to the SA). The DON stated she was "not aware" why they were done after the investigation was completed and the NA identified had already returned to work. Further, the DON verified R6 was to have two people present for transfers per her care plan which was in-effect at the time of the incident on 11/14/19. The NA was re-educated; however, there was no documented evidence she could find demonstrating any subsequent monitoring or audits had been completed of the NA's care since to ensure care plans were being followed.

The facility' Vulnerable Adult - MN policy, revised 10/31/19, identified all staff members must report suspected or alleged abuse immediately and added, "The administrator is responsible for the implementation of the policy." The policy directed all reports of suspected or alleged abuse would be " ... promptly and thoroughly investigated," which included collecting data around the incident, a physical examination of the resident(s) for signs of abuse and interviews with other residents and staff members. The policy directed, "Document the results of the investigation," and

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F 610	Continued From page 27 log the incident on a facility Event Summary.	F 610		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F 636		8/25/20

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F 636	Continued From page 28 (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure triggered Care Area Assessments (CAAs) on a significant change in status Minimum Data Set (MDS) were completed to ensure a comprehensive resident assessment for 1 of 2 residents (R1) reviewed for dementia care and services. Findings include: The Centers for Medicare & Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2018, identified the RAI helps nursing home	F 636	Regarding cited resident: Resident #1 was deceased prior to visit. Actions taken to identify other potential residents having similar occurrences: • Weekly audits of CAA's to verify MDS nurse completion x 4 weeks. • Perform audit of all Admission, Significant Change, and annual MDS's completed since 7/20/20 to ensure completion of CAA's Measures put in place to ensure deficient practice does not recur:	

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F 636	Continued From page 29 staff gather information on each resident to help ensure care plans are developed and revised. The manual outlined, under Chapter 4: Care Area Assessment (CAA) Process and Care Planning, the RAI consisted of three components which includes the MDS, the CAAs, and the RAI Utilization Guidelines. The manual identified CAAs were required to be completed for OBRA comprehensive assessments (i.e. admission, annual, significant change in status, or significant correction of a prior comprehensive). R1's significant change in status MDS, dated 10/28/19, identified R1 had anxiety disorder and depression along with both short and long-term memory impairment. The MDS identified R1 consumed daily anti-anxiety and anti-depressant medications, and demonstrated other behavioral symptoms not directed at others (i.e. hitting or scratching self, public sexual acts, disruptive sounds) 1 to 3 times during the look-back period. Further, under Section V of the MDS, the triggered CAA(s) to be completed were identified with included, "02. Cognitive Loss/Dementia," and, "09. Behavioral Symptoms." Both of these triggered CAA(s) had dictation present which read, "See CAA summary." R1's medical record was reviewed and lacked evidence the triggered CAA(s) for R1's cognition and behavioral symptoms had been completed. Further, R1's CAAs Summary listing, printed 7/17/20, identified a red colored "!" next to each of the CAA(s) which had triggered for the assessment along with a corresponding green colored checkmark under the column titled, "Completed." However, despite both the cognition and behavioral symptoms CAA(s) being identified as triggered; there was no green colored	F 636	• MDS nurses perform a cross check of each other's assigned MDS's weekly X 4 weeks to ensure the completion of the CAA's • Review results of audits and determine the need for further auditing/monitoring.	

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F 636	Continued From page 30 checkmark next to them identifying them as completed. When interviewed on 7/20/20, at 10:28 a.m. registered nurse (RN)-C verified she was the RN who completed and signed R1's MDS dated 10/28/19. RN-C stated she had reviewed R1's medical record and was unable to find evidence the triggered CAA(s) had been completed. RN-C explained the facility' social services department was responsible to complete those assigned CAAs, and added she had "once in awhile" noticed they were not getting done. RN-C stated she sends e-mails to persons when they need to be completed, however, does not typically follow-back to ensure they get done. RN-C expressed the facility had not reviewed their processes or done any education to ensure CAAs are completed before the MDS' are submitted since R1's MDS was completed, and added it was important to ensure CAAs are being done as they're "part of the whole assessment." A facility' policy on CAA(s) completion was requested; however, none was received.	F 636		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		8/25/20

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F 684	Continued From page 31	F 684		

by:
Based on interview and document review, the facility failed to ensure care was appropriately coordinated with an outside hematology clinic to reduce the risk of delayed treatment for 1 of 1 residents (R5) reviewed with cognitive impairment and who was sent to a medical appointment unsupervised causing confusion on the reason(s) and course of treatment to be provided.

Findings include:

A Common Entry Point Intake Form, dated 11/10/19, identified a concern received by the State agency (SA) regarding R5. The report outlined R5 had been brought to an off campus medical appointment with no supervision and was unable to explain why he was there to the staff or physician even asking, " ... how much the vet bill would cost him." R5 had a listed guardian who had expressed to facility' staff he was unable to attend the appointment, so he was waiting to hear if it had been re-scheduled. The report outlined, "Due to not having any decision maker available and with him, however, other labs weren't a possibility as [R5] was unable to give consent."

R5's admission Minimum Data Set (MDS), dated 11/5/19, identified R5 had severe cognitive impairment, several medical diagnoses including anemia, coronary artery disease (CAD) and heart failure; and had recorded episodes of shortness of breath (SOB) during the review period.

R5's Referral Form, dated 11/7/19, identified R5 had an appointment at 3:00 p.m. that day with a physician off campus at the clinic. A section labeled, "Nurse Notes/Reason For Referral," was provided which did not list any reasons for the

Regarding cited resident:
- Resident #5 expired.

Actions taken to identify other potential residents having similar occurrences:
- Develop and implement a policy regarding residents who require escort to appointments.
- Assess all residents to determine the potential need for escort to appointments.
- Update resident care plans to reflect assessment outcomes.

Measures put in place to ensure deficient practice does not recur:
- Audit 50% of outside appointments each week for 4 weeks to ensure the residents escort needs were met Discuss at weekly IDT meeting
- Perform quarterly audits of 50% of outside appointments thereafter.
- Retrain staff on escort policy changes as they occur.

Monitoring over time:
- Review/monitor POC appointment audits and implementation of escort policy for compliance and baseline for future audits.
- Monitor the effective and consistent implementation of the policy over time through quarterly audit review.
- Identify opportunities for process improvement and make recommendations regarding audit process and frequency of audits once 100% compliance is achieved for two consecutive audits.

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ELIM HOME	**701 FIRST STREET PRINCETON, MN 55371**

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F 684	Continued From page 32	F 684		

visit to the physician or notes to be addressed; however, merely listed the nursing home' health unit coordinator (HUC) and registered nurse unit manager (RN)-B's name(s) and a telephone number. The physician signed the note on 11/7/19 and provided dictation which read, "Labs," and, "T Bone Marrow Biopsy." R5 was diagnosed with a B12 deficiency and pancytopenia (low counts for all three types of blood cells: red blood cells, white blood cells, and platelets).

R5's corresponding Fairview Geriatric Services note, dated 11/8/19, identified R5 had been seen for an episodic care visit with pancytopenia listed as the main concern. The note outlined R5, "came to follow up with labs that were done on [R5] today. Spoke with the nurse manager to find out what and why labs. [R5] saw [physician] and was at the appointment alone. Not clear why he was there, [R5] did not know and family did not go with. Has known Pancytopenia and so labs done per orders. Nursing already sent them on to the oncologist office or at least spoke with them about the results and so that is where part of the information came from of [R5] being there alone." The note identified R5 as up in a wheelchair and sitting out in the commons area adding, "Will respond to simple questions but with his memory loss, staff anticipate much of his needs." The note listed several orders for R5 which included diuretic medication, laboratory monitoring and reeducation of antipsychotic medication dosing.

R5's progress note(s) identified the following recorded entries: On 10/30/19, R5 admitted to the nursing home. R5 was recorded as not knowing the place or time upon admission. On 11/7/19, a SLUMs test (cognition test) was administered to

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F 684	Continued From page 33	F 684		

R5. He scored 8/30 which the note outlined, " ... this indicates dementia." On 11/8/19, the laboratory called and reported a critical lab value for R5's platelets and hemoglobin. The physician was notified of these. There were no recorded progress notes from the appointment R5 had with the hematology clinic on 11/8/19; and R5 expired on 12/24/19.

R5's medical record was reviewed and lacked evidence the facility had sent or provided the outside hematology clinic with adequate information or guidance to facilitate care and prevent delays in treatment pertaining to R5's appointment on 11/8/19; despite R5 having known cognitive impairment. Further, there was no evidence in the record demonstrating R5's family had been contact and agreed to meet R5 at the appointment to help facilitate communication and treatment with the clinic on the facility's behalf.

During interview on 7/16/20, at 11:22 a.m. nursing assistant (NA)-A stated she recalled R5 residing on the Rum River Unit (locked memory care unit) and described him as forgetful, but easily re-directable. NA-A explained when a resident on the unit has an appointment, the staff bring the resident and a prepared envelope down to the van driver and send them. NA-A stated there typically was not a staff member or family present when they bring the resident down to the van adding, "I don't believe so." NA-A expressed she was not sure why residents from the unit were sent to appointments unsupervised and added, "That's a good question." Further, NA-A stated HUC-A makes appointments for the residents on the Rum River Unit.

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When interviewed on 7/16/20, at 11:31 a.m. licensed practical nurse (LPN)-A explained the process for getting residents on the Rum River Unit to their appointments. LPN-A stated sometimes the family will take them, otherwise they go to off campus appointments using a "HandiVan" service which the HUC will arrange. LPN-A verified staff members do not routinely attend appointments with cognitively impaired residents and stated someone from the nursing home should be contacting family prior to the appointment to ensure someone is going to be there; however, LPN-A acknowledged she "[didn't] know if that actually happens." LPN-A voiced she could "vaguely remember" an episode in the past where a resident had been sent to an appointment and did not know why they were there when they arrived. LPN-A stated she could not recall any revisions or re-education being completed since that incident; however, expressed it was important to ensure someone was with residents at their appointments to advocate for them and ensure accurate reporting is provided to the physicians.

On 7/16/20, at 11:45 a.m. HUC-A was interviewed and verified she made the appointments for the residents residing on the Rum River Unit. HUC-A explained "depending on [a resident's] cognitivity" they will call family and set-up appointments with them to ensure someone meets them at the site. HUC-A voiced she did not make the decision on who did or did not need to be accompanied to appointments, as that was the unit manager' responsibility. HUC-A stated she typically makes a note on the resident's appointment card regarding if family is meeting someone or not, however, these are not saved or placed in the medical record. Further,

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F 684	Continued From page 35	F 684		

HUC-A stated there had not been any revisions or re-education completed with her since R5 resided on the unit adding she was unaware of an incident where R5 had been sent to a medical appointment unsupervised. HUC-A voiced someone should be present "so they are supervised."

When interviewed on 7/16/20, at 12:09 p.m. the HandiVan driver (HVD) stated he picks residents up from the nursing home and typically is given an envelope which he provides to the reception desk at the clinic or hospital. He expressed his service was basically a "desk to desk" service, and someone from the clinic takes over after he checks them in. HVD voiced family, at times, will meet residents from the nursing home at the clinic; however, it was only "maybe 60/40 [percent]" of the time. HVD stated he recalled "a hair memory" of the incident with R5 and, from what he could recall, thought he dropped him off at the clinic on 11/8/19, and R5's son or responsible party was not there so he brought him inside, but did not remain with him. Further, HVD stated since the incident with R5, he had never been contacted by the nursing home to discuss the situation or revise any procedures to ensure residents are met by family or kept safe when left unsupervised at the clinic.

On 7/16/20, at 1:25 p.m. registered nurse unit manager (RN)-B was interviewed. RN-B explained family was always able to attend appointments with residents; however, added "a lot of the times they do go alone." RN-B voiced the HandiVan driver(s) typically waited for the residents at the clinic to her understanding, and added once they're checked in to the clinic appointments, the resident' safety and care

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F 684	Continued From page 36	F 684		

planning becomes the clinic's responsibility and not the nursing homes. RN-B stated there were some residents on the locked memory care unit she "would hesitate" to send alone to appointments, and voiced while the HUC and her do speak about residents and appointments, there was no formal system to decide who needs supervision and who doesn't for appointments. RN-B added, "It's not our policy to make sure somebody's with them."

RN-B then reviewed R5's incident from 11/8/19. RN-B explained R5 had dementia and could self-propel in his wheelchair. RN-B stated R5 was a resident who probably should have had family or a staff member present with him at off campus appointments as he would likely not give the physician accurate information on his condition(s). RN-B recalled R5's 11/8/19 appointment and stated the clinic had contacted her via telephone when he arrived and she remembered them "being upset" and questioning why R5 was at the clinic. RN-B stated clinic's calling and not having adequate information or having situations where the resident is unable to provide the necessary input for the physician had happened before; however, RN-B felt it was "very rarely." When questioned on her follow-up actions to ensure a similar situation like R5's incident on 11/8/19 did not reoccur, RN-B stated she did "probably nothing;" however, in hindsight, should have brought the clinic' concerns to someone's attention so they could review their system for sending people to appointments.

On 7/16/20, at 2:26 p.m. the director of nursing (DON) and RN-B were interviewed. The DON voiced the nursing home's responsibility was to setup the appointment and arrange transportation

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F 684	Continued From page 37 and she "cannot verify" if anyone from the nursing home contacts family to ensure they will be attending with the resident or not. DON added, "I assume they would," and she felt that was occurring. The DON stated she felt the incident with R5 on 11/8/19 happened due to miscommunication between the physician office and R5's family as the nursing home "did our part" and arranged the transportation for R5. RN-B and the DON verified they had not reviewed their systems or procedures for sending residents to appointments and ensuring care is coordinated and needed information relayed to the providers. The DON voiced she "didn't know this was a thing" and "had we known" she would have acted on it and "maybe put something in place." A facility policy on coordination of care with outside providers was not provided.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure precautions and appropriate supervision was provided to reduce the risk of accidents or injuries for 1 of 1 residents (R5) reviewed who had severe cognitive impairment and was sent to a medical	F 689	Regarding cited resident: • Resident # 5 has expired. Actions taken to identify other potential residents having similar occurrences: • Develop and implement a policy	8/25/20

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F 689	Continued From page 38 appointment off campus unsupervised. Findings include: A Common Entry Point Intake Form, dated 11/10/19, identified a concern received by the State agency (SA) regarding R5. The report outlined R5 had been brought to an off campus medical appointment with no supervision and was unable to explain why he was there to the staff or physician even asking, " ... how much the vet bill would cost him." R5 had a listed guardian who had expressed to facility' staff he was unable to attend the appointment, so he was waiting to hear if it had been re-scheduled. The report outlined concern as sending R5 to the appointment with nobody present could be unsafe. R5's admission Minimum Data Set (MDS), dated 11/5/19, identified R5 had severe cognitive impairment and required extensive assistance with transfers. Further, the MDS identified R5 had sustained a fall with a fracture within the past six months. R5's undated 48 Hour Initial Plan of Care identified R5 was orientated to self and experienced hallucinations with handwritten dictation present reading, "Thinks something is there, Has conversations no one there [sic]." Further, the care plan identified R5 had a history of frequent falls and wandering. R5's Referral Form, dated 11/7/19, identified R5 had an appointment at 3:00 p.m. that day with a physician off campus at the clinic. A section labeled, "Nurse Notes/Reason For Referral," was provided which did not list any reasons for the visit to the physician or notes to be addressed;	F 689	regarding residents who require escort to appointments. • Assess all residents to determine the potential need for escort to appointments. • Update resident care plans to reflect assessment outcomes. Measures put in place to assess deficient practice: • Audit 50% of outside appointments each week for 4 weeks to ensure the residents escort needs were met. Discuss at weekly IDT meeting. • Perform quarterly audits of 50% of outside appointments thereafter. • Develop guideline for staff to follow when making resident appointments and provide to staff who schedule appointments. Monitoring over time: • Monitor policy and guideline implementation compliance over time through review of quarterly audits of scheduled external appointments. • Identify opportunities for process improvement and make recommendations for process change. • Determine the need for ongoing audit based on consistent compliance with policy.	

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F 689	Continued From page 39	F 689		

however, merely listed the nursing home' health unit coordinator (HUC) and registered nurse unit manager (RN)-B's name(s) and a telephone number. The physician signed the note on 11/7/19 and provided dictation which read, "Labs," and, "T Bone Marrow Biopsy." R5 was diagnosed with a B12 deficiency and pancytopenia (low counts for all three types of blood cells: red blood cells, white blood cells, and platelets). There was no recorded directions, including level of assistance and any precautions for R5, to ensure he remained safe while off campus at the appointment.

R5's corresponding Fairview Geriatric Services note, dated 11/8/19, identified R5 had been seen for an episodic care visit with pancytopenia listed as the main concern. The note outlined R5, "came to follow up with labs that were done on [R5] today. Spoke with the nurse manager to find out what and why labs. [R5] saw [physician] and was at the appointment alone. Not clear why he was there, [R5] did not know and family did not go with." The note identified R5 as up in a wheelchair and sitting out in the commons area adding, "Will respond to simple questions but with his memory loss, staff anticipate much of his needs." The note listed several orders for R5 which included diuretic medication, laboratory monitoring and reeducation of antipsychotic medication dosing.

R5's progress note(s) identified the following recorded entries: On 10/30/19, R5 admitted to the nursing home. R5 was recorded as not knowing the place or time upon admission. On 11/7/19, a SLUMs test (cognition test) was administered to R5. He scored 8/30 which the note outlined, " ... this indicates dementia." On 11/8/19, the

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F 689	Continued From page 40	F 689		

laboratory called and reported a critical lab value for R5's platelets and hemoglobin. The physician was notified of these. There were no recorded progress notes from the appointment R5 had with the hematology clinic on 11/8/19; and R5 expired on 12/24/19.

R5's medical record was reviewed and lacked evidence the facility had arranged family or staff to accompany R5 to his medical appointment on 11/8/19, despite being identified with severe cognitive impairment and a history of wandering and falls. Further, the record lacked evidence the facility had communicated to the clinic staff on needed levels of assistance or any needed safety precautions to ensure R5 was kept safe and free of accidents if he needed to be transferred, use the restroom, or attempted to leave the clinic unsupervised.

When interviewed on 7/16/20, at 11:22 a.m. nursing assistant (NA)-A stated she recalled R5 residing on the Rum River Unit (locked memory care unit) and described him as forgetful, but easily re-directable. NA-A explained when a resident on the unit has an appointment, the staff bring the resident and a prepared envelope down to the van driver and send them. NA-A stated there typically was not a staff member or family present when they bring the resident down to the van adding, "I don't believe so." NA-A expressed she was not sure why residents from the unit were sent to appointments unsupervised and added, "That's a good question." Further, NA-A stated R5 used to often verbalize he wanted to go home and she could see R5 becoming confused at the appointment and "wondering why he isn't home" and "wanting to go home" then trying to leave the clinic.

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F 689	Continued From page 41	F 689		

On 7/16/20, at 11:45 a.m. HUC-A was interviewed and verified she made the appointments for the residents residing on the Rum River Unit. HUC-A explained depending on a residents cognition they will call family and set-up appointments with them to ensure someone meets them at the site. HUC-A voiced she did not make the decision on who did or did not need to be accompanied to appointments, as that was the unit manager' responsibility. HUC-A stated she typically makes a note on the resident's appointment card regarding if family is meeting someone or not, however, these are not saved or placed in the medical record. Further, HUC-A stated there had not been any revisions or re-education completed with her since R5 resided on the unit adding she was unaware of an incident where R5 had been sent to a medical appointment unsupervised. HUC-A voiced someone should be present "so they are supervised."

When interviewed on 7/16/20, at 12:09 p.m. the HandiVan driver (HVD) stated he picks residents up from the nursing home and typically is given an envelope which he provides to the reception desk at the clinic or hospital. He expressed his service was basically a "desk to desk" service, and someone from the clinic takes over after he checks them in. HVD voiced family, at times, will meet residents from the nursing home at the clinic; however, it was only "maybe 60/40 [percent]" of the time. HVD verified he does not remain with the person while they're at the clinic, and if no family is present, he leaves then let's the resident see the physician. HVD stated he recalled "a hair memory" of the incident with R5 and, from what he could recall, thought he

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F 689	Continued From page 42	F 689		

dropped him off at the clinic on 11/8/19, and R5's son or responsible party was not there so he brought him inside, but did not remain with him. Further, HVD stated since the incident with R5, he had never been contacted by the nursing home to discuss the situation or revise any procedures to ensure residents are met by family or kept safe when left unsupervised at the clinic.

On 7/16/20, at 1:25 p.m. registered nurse unit manager (RN)-B was interviewed. RN-B explained family was always able to attend appointments with residents; however, added "a lot of the times they do go alone." RN-B voiced the HandiVan driver(s) typically waited for the residents at the clinic to her understanding, and added once they're checked in to the clinic appointments, the resident' safety and care planning becomes the clinic's responsibility and not the nursing homes. RN-B stated there were some residents on the locked memory care unit she "would hesitate" to send alone to appointments, and voiced while the HUC and her do speak about residents and appointments, there was no formal system to decide who needs supervision and who doesn't for appointments. RN-B added, "It's not our policy to make sure somebody's with them." RN-B then reviewed R5's incident from 11/8/19. RN-B explained R5 had dementia and could self-propel in his wheelchair. RN-B added, at times, she recalled R5 as someone who did become confused and search for people to take him to various places. RN-B stated R5 was a resident who probably should have had family or a staff member present with him at off campus appointments as he would likely not give the physician accurate information on his condition(s). RN-B stated she didn't think much, if any, information on activities of daily

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F 689	Continued From page 43 living (ADL) assistance or supervision interventions (i.e. to prevent falls or elopements) were sent with residents on appointments adding, "We don't do a whole lot of that kind of stuff." RN-B recalled R5's 11/8/19 appointment and stated the clinic had contacted her via telephone when he arrived and she remembered them "being upset" and questioning why R5 was at the clinic. When questioned on her follow-up actions to ensure a similar situation like R5's incident on 11/8/19 did not reoccur, RN-B stated she did "probably nothing;" however, in hindsight, should have brought the clinic' concerns to someone's attention so they could review their system for sending people to appointments and make sure they're supervised appropriately. On 7/16/20, at 2:26 p.m. the director of nursing (DON) and RN-B were interviewed. The DON voiced the nursing home's responsibility was to setup the appointment and arrange transportation and she "cannot verify" if anyone from the nursing home contacts family to ensure they will be attending with the resident or not. DON added, "I assume they would," and she felt that was occurring. RN-B and the DON verified they had not reviewed their systems or procedures for sending residents to appointments and ensuring care is coordinated and supervision is provided. The DON voiced she "didn't know this was a thing" and "had we known" she would have acted on it and "maybe put something in place." A facility policy on supervision of residents while at appointments was not provided.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		8/25/20

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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 744	Continued From page 44 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess and develop interventions to reduce behaviors and promote well-being for 1 of 2 residents (R1) reviewed who displayed exit seeking and delusional behaviors which were not effectively addressed. Findings include: R1's significant change Minimum Data Set (MDS), dated 10/28/19, identified R1 had short and long-term memory impairment along with severely impaired cognitive skills for daily decision making. The MDS identified R1 demonstrated behavioral symptoms (i.e. hitting or scratching self, public sexual acts, screaming) during the review period; and the Care Area Assessment (CAA) for cognition and behavioral symptoms were listed as being triggered to be completed. R1's care plan, last revised 5/5/20, identified R1 received mood stabilizing medication(s) and listed targeted behaviors which included anger, restlessness, disrobing in public and repeated statements. A series of goals were listed for R1 which included using less medications and having less than two reports of anxious verbalizations daily. The care plan listed several interventions to meet the established goals which included documenting the resident's behaviors and mood,	F 744	Regarding cited resident: • Resident # 1 expired 1/16/20 Actions taken to identify other potential residents having similar occurrences: • Review and update the Behavioral Health policy. • Re-initiate dementia unit behavioral meetings. • Review all residents over the next quarter to coincide with scheduled care conferences. Measures put in place to assess deficient practice: • Audit 100% of behavioral care plans over the next quarter to assess for intervention effectiveness. • Conduct quarterly audits of 100% of behavioral care plans. • Retrain staff on policy changes as they occur Monitoring over time: • Conduct review of quarterly behavioral care plan audit results to identify deficient areas of practice. • Determine opportunities for process improvement.	

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	245494	A. BUILDING _____ B. WING _____	C 07/20/2020

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F 744	Continued From page 45	F 744		

intervening as needed, and providing 1:1 visits or reassurance to her when distressed.

R1's progress note, dated 10/28/19, identified R1 was being reviewed for a significant change in status assessment. A note was completed by registered nurse unit manager (RN)-B which identified, "Behavior: per the Target behavior charting crying was reported on 1 day. Verbally exhibiting anxiety was reported on 5 evenings with redirection and offering a snack or activity not being effective. Inability to sleep was reported X 5 days with reading material, TV, and snacks not being effective. Delusional comments reported daily with redirection and 1-1 visits not being effective. Exit seeking reported on 2 days with redirection and 1-1 not being effective."

R1's subsequent progress note(s) were reviewed and identified the following: On 11/17/19, R1 had a verbal altercation with another resident. On 11/27/19, R1 was recorded as being, "...aggressive towards other residents this shift. Resident has increase [sic] anxiety, grand thoughts, and cursing. PRN [as needed] administered, which was somewhat effective." Further, on 12/7/19, R1 was attempted to go into other resident' rooms and when re-directed threw her coloring box on the floor and became upset. R1 was recorded as expiring on 1/16/20.

R1's subsequent Target Behavior Monitoring flowsheets, dated 11/2019 to 1/2020, identified the following:

November 2019: R1 had five episodes of exit seeking with each of the episodes having interventions completed, including coloring or taking off the unit, however, each time these

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F 744	Continued From page 46	F 744		

interventions were recorded the behavior was recorded as, "Unchanged." R1 had six episodes of crying and/or weeping recorded with interventions completed, including reassurance and offering snacks or activities, however, each time these interventions were recorded the behavior was recorded as, "Unchanged." R1 had 10 episodes of verbal complaints of anxiety recorded with each of the episodes having interventions completed. However, again, all of these recorded episodes had the behaviors recorded as, "Unchanged," despite the interventions. R1 had 13 episodes of inability to sleep recorded, each having interventions listed which included massage, warm packs and snacks; however, again, all of these episodes recorded the behavior as, "Unchanged," despite the interventions. Further, R1 had 22 episodes of delusional comments recorded with interventions being completed, including redirection and 1:1 visits, however each time these interventions were recorded the behavior was recorded as, "Unchanged."

December 2019: R1 had eight episodes of exit seeking with each of the episodes having interventions completed, including coloring or taking R1 off the unit, however, only one of the episodes was recorded as these interventions being effective. The other episodes recorded the behavior as, "Unchanged." R1 had one episode of crying and/or weeping recorded with interventions completed, including reassurance and offering snacks or activities, however, these interventions were not effective and the behavior was recorded as, "Unchanged." R1 had four episodes of verbal complaints of anxiety recorded with each of the episodes having interventions completed. However, again, all of these recorded

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F 744	Continued From page 47	F 744		

episodes had the behaviors recorded as, "Unchanged," despite the interventions. R1 had seven episodes of inability to sleep recorded with each of the episodes having interventions completed which included massage, warm packs and snacks; however, again, all of these episodes recorded the behavior as, "Unchanged," despite the interventions. Further, R1 had 14 episodes of delusional comments recorded with interventions being completed, including redirection and 1:1 visits, however each time these interventions were recorded the behavior was recorded as, "Unchanged."

When interviewed on 7/16/20, at 10:17 a.m. nursing assistant (NA)-D voiced she recalled R1 and verified she resided on the Rum River Unit (locked memory care unit). R1 was able to self-propel in her wheelchair and often used, or attempted to use, other resident' bathrooms on the unit. NA-D recalled R1 had exit seeking behaviors and would often go around the unit "kicking, pounding on doors and swearing." NA-D expressed R1 was re-directable at times, and if not, the staff would give her medications which helped "most of the time." Further, NA-D stated any demonstrated behaviors from R1 were reported to the nurse(s) and added she felt R1's behaviors had gotten "maybe slightly worse" in the months leading up to her death in January 2020.

R1's medical record was reviewed and lacked evidence R1 had been comprehensively reassessed and new interventions developed to reduce R1's identified behaviors despite the behaviors, and implemented interventions, being recorded in the progress note(s) as not effective. Further, the medical record lacked any evidence

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F 744	Continued From page 48	F 744		

a CAA had been completed for R5's cognition and behavioral symptoms despite being triggered on the 10/28/19 MDS (See F636 for additional information).

On 7/16/20, at 2:01 p.m. RN-B was interviewed and verified she was R1's care manager during the last months of her life at the nursing home. RN-B explained when a resident displays behavior(s), the staff attempt to observe the behavior and try to intervene by coming up with "things they like." The unit used to have behavior meetings which helped in this process, however, they had not had a meeting for "a few months" as other things took priority. RN-B stated the facility typically accomplished the behavioral assessment by discussing them "informally." On 7/17/20, at 9:08 a.m. a subsequent interview was held with RN-B. The last time R1 had been reviewed at the behavior meetings, at least to which RN-B could find evidence supporting, was in July 2019. They decided at the meeting to implement a "calming activities" intervention, however, RN-B voiced it had never been added to the care plan and should have been. Further, RN-B reviewed the medical record and verified there was no comprehensive assessment completed regarding R1's behaviors, despite the implemented interventions being listed as not effective and R1 continuing to have the same behaviors, and reiterated the system in place for assessing behaviors was the monthly meetings which had "fallen by the wayside."

A provided Behavioral Health Services policy, dated 5/31/19, identified behavioral health encompasses a resident's whole emotional and mental well-being. The facility was to use " ... a comprehensive assessment process for

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F 744	Continued From page 49 identifying and assessing a resident's mental and psychosocial status and providing person-centered care." This assessment included obtaining information from medical records, family and/or the resident on usual patterns of cognition or mood and behavior; and, using the Resident Assessment Instrument (RAI) process including the MDS and CAA(s).	F 744		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		8/25/20

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F 880	Continued From page 50 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document	F 880	Regarding cited resident:	

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F 880	Continued From page 51 review the facility failed to ensure all employees were being actively screened (other employees verifying temperature readings during the screening process) for the prevention and potential transmission of corona virus (COVID-19), in accordance with the Centers for Disease Control (CDC) guidelines. This had the potential to affect all 92 residents currently residing in the facility at the time of the COVID-19 survey. Findings Include: A Centers for Medicare and Medicaid (CMS) COVID-19 Long-Term Care Facility Guidance, dated 4/2/20, identified procedures to be implemented to reduce the risk of COVID-19 transmission in a long-term care setting. This included, " ... every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked." On 7/17/20, at approximately 8:55 a.m. survey team entered facility through the main doors. At that time, survey staff observed three facility employees self screening with no verification of their temperature or COVID screening questions with another employee before entering the facility despite an employee being present at the screening table at the time (employee was screening survey staff). When interviewed on 7/17/20, at 11:49 a.m. dietary aide (DA-A) stated when arriving to work she answered questions and took her own temperature. DA-A said, "There is always	F 880	• Screen all residents for signs/symptoms of COVID-19 each shift to include temperature and symptom screen. Upon initiation of process, resident baseline was 100% negative for signs/symptoms. Actions taken to identify other potential residents having similar occurrences: • Staff training on COVID-19 Screening policy. • Root Cause Analysis • Place more comprehensive signage at screening area, notifying staff of screening requirements. • Assign staff to screening station at the beginning of each shift. During off times, the receptionist will screen or, staff will call nursing staff to screen staff/outside essential workers/visitors who enter the building. Measures put in place to ensure deficient practice does not recur: • Conduct observation audits of the screening station 4x/week for 1 week, 2x/week for 1 week and biweekly thereafter, until 100% compliance is achieved. • Review audit findings and alter screening process, if necessary. Effective implementation of actions will be monitored by: • Review audit results to determine the need for further auditing/ monitoring.	

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F 880	Continued From page 52 someone there to make sure you are doing the screening." DA-A stated she did not know of anyone "needing to check my temperature". DA-A stated again she self-administered her own temperature and documented the results in the symptoms section of the screening process. When interviewed on 7/17/20, at 1:29 p.m. the director of nursing (DON) stated at the screening table there was always to be someone around to assist with the screening process. DON explained the screening process consisted of answering questions about symptoms and taking temperature. DON stated temperature monitoring was having "someone else" look at the temperature to verify result. DON stated there was a schedule for helping employees screen and someone was to be at the screening area to assist with all screening to verify information. DON stated she was not aware of employees not verifying temperatures. DON further explained employees had been educated on the screening process which included showing another employee verifying temperature results. Policy entitled COVID-19 Phase 2-All SNFs and all CO sites states, "healthcare workers will complete a symptom screening form, including having their temperature checked .....these forms will be reviewed by a facility designee prior to reporting to the resident care area".	F 880	• Other recommendations	

Electronically delivered
August 6, 2020

Administrator
Elim Home
701 First Street
Princeton, MN 55371

Re: State Nursing Home Licensing Orders
Event ID: 8VDD11

Dear Administrator:

The above facility was surveyed on July 16, 2020 through July 20, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356

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

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

Please feel free to call me with any questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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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 7/16/20 to 7/20/20, a survey was conducted by surveyors from the Minnesota Department of Health (MDH) to determine compliance for state licensure in conjuction with complaint investigation(s) for H5494042C, H5494043C, H5494044C, H5494045C, H5494046C, H5494047C, H5494048C, H5494049C,	2 000		

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2 000	Continued From page 1 H5494050C. As a result, the following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected. 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential;	2 540		8/25/20

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2 540	Continued From page 3 K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure triggered Care Area Assessments (CAAs) on a significant change in status Minimum Data Set (MDS) were completed to ensure a comprehensive resident assessment for 1 of 2 residents (R1) reviewed for dementia care and services. Findings include: The Centers for Medicare & Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2018, identified the RAI helps nursing home staff gather information on each resident to help ensure care plans are developed and revised. The manual outlined, under Chapter 4: Care Area Assessment (CAA) Process and Care Planning, the RAI consisted of three components which includes the MDS, the CAAs, and the RAI Utilization Guidelines. The manual identified CAAs were required to be completed for OBRA comprehensive assessments (i.e. admission, annual, significant change in status, or significant correction of a prior comprehensive). R1's significant change in status MDS, dated 10/28/19, identified R1 had anxiety disorder and depression along with both short and long-term memory impairment. The MDS identified R1 consumed daily anti-anxiety and anti-depressant medications, and demonstrated other behavioral symptoms not directed at others (i.e. hitting or scratching self, public sexual acts, disruptive sounds) 1 to 3 times during the look-back period. Further, under Section V of the MDS, the	2 540	Corrected	

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2 540	Continued From page 4 triggered CAA(s) to be completed were identified with included, "02. Cognitive Loss/Dementia," and, "09. Behavioral Symptoms." Both of these triggered CAA(s) had dictation present which read, "See CAA summary." R1's medical record was reviewed and lacked evidence the triggered CAA(s) for R1's cognition and behavioral symptoms had been completed. Further, R1's CAAs Summary listing, printed 7/17/20, identified a red colored "!" next to each of the CAA(s) which had triggered for the assessment along with a corresponding green colored checkmark under the column titled, "Completed." However, despite both the cognition and behavioral symptoms CAA(s) being identified as triggered; there was no green colored checkmark next to them identifying them as completed. When interviewed on 7/20/20, at 10:28 a.m. registered nurse (RN)-C verified she was the RN who completed and signed R1's MDS dated 10/28/19. RN-C stated she had reviewed R1's medical record and was unable to find evidence the triggered CAA(s) had been completed. RN-C explained the facility' social services department was responsible to complete those assigned CAAs, and added she had "once in awhile" noticed they were not getting done. RN-C stated she sends e-mails to persons when they need to be completed, however, does not typically follow-back to ensure they get done. RN-C expressed the facility had not reviewed their processes or done any education to ensure CAAs are completed before the MDS' are submitted since R1's MDS was completed, and added it was important to ensure CAAs are being done as they're "part of the whole assessment." A facility' policy on CAA(s) completion was requested; however, none was received. SUGGESTED METHOD OF CORRECTION: The	2 540		

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2 540	Continued From page 5 director of nursing (DON), or designee, could review applicable polices and procedures on Care Area Assessment (CAA) completion; then inserivce staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure care was appropriately coordinated with an outside hematology clinic to reduce the risk of delayed treatment for 1 of 1 residents (R5) reviewed with cognitive impairment and who was sent to a medical appointment unsupervised causing confusion on the reason(s) and course of treatment to be provided, failed to ensure precautions and appropriate supervision was provided to reduce the risk of accidents or injuries for 1 of 1 residents (R5) reviewed who had severe cognitive impairment and was sent to	2 830	Corrected	8/25/20

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2 830	Continued From page 6	2 830		

a medical appointment off campus unsupervised and failed to comprehensively reassess and develop interventions to reduce behaviors and promote well-being for 1 of 2 residents (R1) reviewed who displayed exit seeking and delusional behaviors which were not effectively addressed.

Findings include:

Coordination of care
A Common Entry Point Intake Form, dated 11/10/19, identified a concern received by the State agency (SA) regarding R5. The report outlined R5 had been brought to an off campus medical appointment with no supervision and was unable to explain why he was there to the staff or physician even asking, " ... how much the vet bill would cost him." R5 had a listed guardian who had expressed to facility' staff he was unable to attend the appointment, so he was waiting to hear if it had been re-scheduled. The report outlined, "Due to not having any decision maker available and with him, however, other labs weren't a possibility as [R5] was unable to give consent."

R5's admission Minimum Data Set (MDS), dated 11/5/19, identified R5 had severe cognitive impairment, several medical diagnoses including anemia, coronary artery disease (CAD) and heart failure; and had recorded episodes of shortness of breath (SOB) during the review period.

R5's Referral Form, dated 11/7/19, identified R5 had an appointment at 3:00 p.m. that day with a physician off campus at the clinic. A section labeled, "Nurse Notes/Reason For Referral," was provided which did not list any reasons for the visit to the physician or notes to be addressed; however, merely listed the nursing home' health

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2 830	Continued From page 7	2 830		

unit coordinator (HUC) and registered nurse unit manager (RN)-B's name(s) and a telephone number. The physician signed the note on 11/7/19 and provided dictation which read, "Labs," and, "T Bone Marrow Biopsy." R5 was diagnosed with a B12 deficiency and pancytopenia (low counts for all three types of blood cells: red blood cells, white blood cells, and platelets).

R5's corresponding Fairview Geriatric Services note, dated 11/8/19, identified R5 had been seen for an episodic care visit with pancytopenia listed as the main concern. The note outlined R5, "came to follow up with labs that were done on [R5] today. Spoke with the nurse manager to find out what and why labs. [R5] saw [physician] and was at the appointment alone. Not clear why he was there, [R5] did not know and family did not go with. Has known Pancytopenia and so labs done per orders. Nursing already sent them on to the oncologist office or at least spoke with them about the results and so that is where part of the information came from of [R5] being there alone." The note identified R5 as up in a wheelchair and sitting out in the commons area adding, "Will respond to simple questions but with his memory loss, staff anticipate much of his needs." The note listed several orders for R5 which included diuretic medication, laboratory monitoring and reeducation of antipsychotic medication dosing.

R5's progress note(s) identified the following recorded entries: On 10/30/19, R5 admitted to the nursing home. R5 was recorded as not knowing the place or time upon admission. On 11/7/19, a SLUMs test (cognition test) was administered to R5. He scored 8/30 which the note outlined, " ... this indicates dementia." On 11/8/19, the laboratory called and reported a critical lab value

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2 830	Continued From page 8	2 830		

for R5's platelets and hemoglobin. The physician was notified of these. There were no recorded progress notes from the appointment R5 had with the hematology clinic on 11/8/19; and R5 expired on 12/24/19.

R5's medical record was reviewed and lacked evidence the facility had sent or provided the outside hematology clinic with adequate information or guidance to facilitate care and prevent delays in treatment pertaining to R5's appointment on 11/8/19; despite R5 having known cognitive impairment. Further, there was no evidence in the record demonstrating R5's family had been contact and agreed to meet R5 at the appointment to help facilitate communication and treatment with the clinic on the facility's behalf.

During interview on 7/16/20, at 11:22 a.m. nursing assistant (NA)-A stated she recalled R5 residing on the Rum River Unit (locked memory care unit) and described him as forgetful, but easily re-directable. NA-A explained when a resident on the unit has an appointment, the staff bring the resident and a prepared envelope down to the van driver and send them. NA-A stated there typically was not a staff member or family present when they bring the resident down to the van adding, "I don't believe so." NA-A expressed she was not sure why residents from the unit were sent to appointments unsupervised and added, "That's a good question." Further, NA-A stated HUC-A makes appointments for the residents on the Rum River Unit.

When interviewed on 7/16/20, at 11:31 a.m. licensed practical nurse (LPN)-A explained the process for getting residents on the Rum River Unit to their appointments. LPN-A stated

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2 830	Continued From page 9 sometimes the family will take them, otherwise they go to off campus appointments using a "HandiVan" service which the HUC will arrange. LPN-A verified staff members do not routinely attend appointments with cognitively impaired residents and stated someone from the nursing home should be contacting family prior to the appointment to ensure someone is going to be there; however, LPN-A acknowledged she "[didn't] know if that actually happens." LPN-A voiced she could "vaguely remember" an episode in the past where a resident had been sent to an appointment and did not know why they were there when they arrived. LPN-A stated she could not recall any revisions or re-education being completed since that incident; however, expressed it was important to ensure someone was with residents at their appointments to advocate for them and ensure accurate reporting is provided to the physicians. On 7/16/20, at 11:45 a.m. HUC-A was interviewed and verified she made the appointments for the residents residing on the Rum River Unit. HUC-A explained "depending on [a resident's] cognitivity" they will call family and set-up appointments with them to ensure someone meets them at the site. HUC-A voiced she did not make the decision on who did or did not need to be accompanied to appointments, as that was the unit manager' responsibility. HUC-A stated she typically makes a note on the resident's appointment card regarding if family is meeting someone or not, however, these are not saved or placed in the medical record. Further, HUC-A stated there had not been any revisions or re-education completed with her since R5 resided on the unit adding she was unaware of an incident where R5 had been sent to a medical appointment unsupervised. HUC-A voiced	2 830		

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2 830	Continued From page 10 someone should be present "so they are supervised." When interviewed on 7/16/20, at 12:09 p.m. the HandiVan driver (HVD) stated he picks residents up from the nursing home and typically is given an envelope which he provides to the reception desk at the clinic or hospital. He expressed his service was basically a "desk to desk" service, and someone from the clinic takes over after he checks them in. HVD voiced family, at times, will meet residents from the nursing home at the clinic; however, it was only "maybe 60/40 [percent]" of the time. HVD stated he recalled "a hair memory" of the incident with R5 and, from what he could recall, thought he dropped him off at the clinic on 11/8/19, and R5's son or responsible party was not there so he brought him inside, but did not remain with him. Further, HVD stated since the incident with R5, he had never been contacted by the nursing home to discuss the situation or revise any procedures to ensure residents are met by family or kept safe when left unsupervised at the clinic. On 7/16/20, at 1:25 p.m. registered nurse unit manager (RN)-B was interviewed. RN-B explained family was always able to attend appointments with residents; however, added "a lot of the times they do go alone." RN-B voiced the HandiVan driver(s) typically waited for the residents at the clinic to her understanding, and added once they're checked in to the clinic appointments, the resident' safety and care planning becomes the clinic's responsibility and not the nursing homes. RN-B stated there were some residents on the locked memory care unit she "would hesitate" to send alone to appointments, and voiced while the HUC and her do speak about residents and appointments,	2 830		

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there was no formal system to decide who needs supervision and who doesn't for appointments. RN-B added, "It's not our policy to make sure somebody's with them."

RN-B then reviewed R5's incident from 11/8/19. RN-B explained R5 had dementia and could self-propel in his wheelchair. RN-B stated R5 was a resident who probably should have had family or a staff member present with him at off campus appointments as he would likely not give the physician accurate information on his condition(s). RN-B recalled R5's 11/8/19 appointment and stated the clinic had contacted her via telephone when he arrived and she remembered "being upset" and questioning why R5 was at the clinic. RN-B stated clinic's calling and not having adequate information or having situations where the resident is unable to provide the necessary input for the physician had happened before; however, RN-B felt it was "very rarely." When questioned on her follow-up actions to ensure a similar situation like R5's incident on 11/8/19 did not reoccur, RN-B stated she did "probably nothing;" however, in hindsight, should have brought the clinic' concerns to someone's attention so they could review their system for sending people to appointments.

On 7/16/20, at 2:26 p.m. the director of nursing (DON) and RN-B were interviewed. The DON voiced the nursing home's responsibility was to setup the appointment and arrange transportation and she "cannot verify" if anyone from the nursing home contacts family to ensure they will be attending with the resident or not. DON added, "I assume they would," and she felt that was occurring. The DON stated she felt the incident with R5 on 11/8/19 happened due to miscommunication between the physician office

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and R5's family as the nursing home "did our part" and arranged the transportation for R5. RN-B and the DON verified they had not reviewed their systems or procedures for sending residents to appointments and ensuring care is coordinated and needed information relayed to the providers. The DON voiced she "didn't know this was a thing" and "had we known" she would have acted on it and "maybe put something in place."

A facility policy on coordination of care with outside providers was not provided.

Accidents
A Common Entry Point Intake Form, dated 11/10/19, identified a concern received by the State agency (SA) regarding R5. The report outlined R5 had been brought to an off campus medical appointment with no supervision and was unable to explain why he was there to the staff or physician even asking, " ... how much the vet bill would cost him." R5 had a listed guardian who had expressed to facility' staff he was unable to attend the appointment, so he was waiting to hear if it had been re-scheduled. The report outlined concern as sending R5 to the appointment with nobody present could be unsafe.

R5's admission Minimum Data Set (MDS), dated 11/5/19, identified R5 had severe cognitive impairment and required extensive assistance with transfers. Further, the MDS identified R5 had sustained a fall with a fracture within the past six months.

R5's undated 48 Hour Initial Plan of Care identified R5 was orientated to self and experienced hallucinations with handwritten dictation present reading, "Thinks something is there, Has conversations no one there [sic]."

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2 830	Continued From page 13 Further, the care plan identified R5 had a history of frequent falls and wandering. R5's Referral Form, dated 11/7/19, identified R5 had an appointment at 3:00 p.m. that day with a physician off campus at the clinic. A section labeled, "Nurse Notes/Reason For Referral," was provided which did not list any reasons for the visit to the physician or notes to be addressed; however, merely listed the nursing home' health unit coordinator (HUC) and registered nurse unit manager (RN)-B's name(s) and a telephone number. The physician signed the note on 11/7/19 and provided dictation which read, "Labs," and, "T Bone Marrow Biopsy." R5 was diagnosed with a B12 deficiency and pancytopenia (low counts for all three types of blood cells: red blood cells, white blood cells, and platelets). There was no recorded directions, including level of assistance and any precautions for R5, to ensure he remained safe while off campus at the appointment. R5's corresponding Fairview Geriatric Services note, dated 11/8/19, identified R5 had been seen for an episodic care visit with pancytopenia listed as the main concern. The note outlined R5, "came to follow up with labs that were done on [R5] today. Spoke with the nurse manager to find out what and why labs. [R5] saw [physician] and was at the appointment alone. Not clear why he was there, [R5] did not know and family did not go with." The note identified R5 as up in a wheelchair and sitting out in the commons area adding, "Will respond to simple questions but with his memory loss, staff anticipate much of his needs." The note listed several orders for R5 which included diuretic medication, laboratory monitoring and reeducation of antipsychotic medication dosing.	2 830		

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R5's progress note(s) identified the following recorded entries: On 10/30/19, R5 admitted to the nursing home. R5 was recorded as not knowing the place or time upon admission. On 11/7/19, a SLUMs test (cognition test) was administered to R5. He scored 8/30 which the note outlined, " ... this indicates dementia." On 11/8/19, the laboratory called and reported a critical lab value for R5's platelets and hemoglobin. The physician was notified of these. There were no recorded progress notes from the appointment R5 had with the hematology clinic on 11/8/19; and R5 expired on 12/24/19.

R5's medical record was reviewed and lacked evidence the facility had arranged family or staff to accompany R5 to his medical appointment on 11/8/19, despite being identified with severe cognitive impairment and a history of wandering and falls. Further, the record lacked evidence the facility had communicated to the clinic staff on needed levels of assistance or any needed safety precautions to ensure R5 was kept safe and free of accidents if he needed to be transferred, use the restroom, or attempted to leave the clinic unsupervised.

When interviewed on 7/16/20, at 11:22 a.m. nursing assistant (NA)-A stated she recalled R5 residing on the Rum River Unit (locked memory care unit) and described him as forgetful, but easily re-directable. NA-A explained when a resident on the unit has an appointment, the staff bring the resident and a prepared envelope down to the van driver and send them. NA-A stated there typically was not a staff member or family present when they bring the resident down to the van adding, "I don't believe so." NA-A expressed she was not sure why residents from the unit

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were sent to appointments unsupervised and added, "That's a good question." Further, NA-A stated R5 used to often verbalize he wanted to go home and she could see R5 becoming confused at the appointment and "wondering why he isn't home" and "wanting to go home" then trying to leave the clinic.

On 7/16/20, at 11:45 a.m. HUC-A was interviewed and verified she made the appointments for the residents residing on the Rum River Unit. HUC-A explained depending on a residents cognition they will call family and set-up appointments with them to ensure someone meets them at the site. HUC-A voiced she did not make the decision on who did or did not need to be accompanied to appointments, as that was the unit manager' responsibility. HUC-A stated she typically makes a note on the resident's appointment card regarding if family is meeting someone or not, however, these are not saved or placed in the medical record. Further, HUC-A stated there had not been any revisions or re-education completed with her since R5 resided on the unit adding she was unaware of an incident where R5 had been sent to a medical appointment unsupervised. HUC-A voiced someone should be present "so they are supervised."

When interviewed on 7/16/20, at 12:09 p.m. the HandiVan driver (HVD) stated he picks residents up from the nursing home and typically is given an envelope which he provides to the reception desk at the clinic or hospital. He expressed his service was basically a "desk to desk" service, and someone from the clinic takes over after he checks them in. HVD voiced family, at times, will meet residents from the nursing home at the clinic; however, it was only "maybe 60/40

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2 830	Continued From page 16 [percent]" of the time. HVD verified he does not remain with the person while they're at the clinic, and if no family is present, he leaves the let's the resident see the physician. HVD stated he recalled "a hair memory" of the incident with R5 and, from what he could recall, thought he dropped him off at the clinic on 11/8/19, and R5's son or responsible party was not there so he brought him inside, but did not remain with him. Further, HVD stated since the incident with R5, he had never been contacted by the nursing home to discuss the situation or revise any procedures to ensure residents are met by family or kept safe when left unsupervised at the clinic. On 7/16/20, at 1:25 p.m. registered nurse unit manager (RN)-B was interviewed. RN-B explained family was always able to attend appointments with residents; however, added "a lot of the times they do go alone." RN-B voiced the HandiVan driver(s) typically waited for the residents at the clinic to her understanding, and added once they're checked in to the clinic appointments, the resident' safety and care planning becomes the clinic's responsibility and not the nursing homes. RN-B stated there were some residents on the locked memory care unit she "would hesitate" to send alone to appointments, and voiced while the HUC and her do speak about residents and appointments, there was no formal system to decide who needs supervision and who doesn't for appointments. RN-B added, "It's not our policy to make sure somebody's with them." RN-B then reviewed R5's incident from 11/8/19. RN-B explained R5 had dementia and could self-propel in his wheelchair. RN-B added, at times, she recalled R5 as someone who did become confused and search for people to take him to various places. RN-B stated R5 was a resident who probably should	2 830		

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have had family or a staff member present with him at off campus appointments as he would likely not give the physician accurate information on his condition(s). RN-B stated she didn't think much, if any, information on activities of daily living (ADL) assistance or supervision interventions (i.e. to prevent falls or elopements) were sent with residents on appointments adding, "We don't do a whole lot of that kind of stuff." RN-B recalled R5's 11/8/19 appointment and stated the clinic had contacted her via telephone when he arrived and she remembered "being upset" and questioning why R5 was at the clinic. When questioned on her follow-up actions to ensure a similar situation like R5's incident on 11/8/19 did not reoccur, RN-B stated she did "probably nothing;" however, in hindsight, should have brought the clinic' concerns to someone's attention so they could review their system for sending people to appointments and make sure they're supervised appropriately.

On 7/16/20, at 2:26 p.m. the director of nursing (DON) and RN-B were interviewed. The DON voiced the nursing home's responsibility was to setup the appointment and arrange transportation and she "cannot verify" if anyone from the nursing home contacts family to ensure they will be attending with the resident or not. DON added, "I assume they would," and she felt that was occurring. RN-B and the DON verified they had not reviewed their systems or procedures for sending residents to appointments and ensuring care is coordinated and supervision is provided. The DON voiced she "didn't know this was a thing" and "had we known" she would have acted on it and "maybe put something in place."

A facility policy on supervision of residents while at appointments was not provided.

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Dementia Care
R1's significant change Minimum Data Set (MDS), dated 10/28/19, identified R1 had short and long-term memory impairment along with severely impaired cognitive skills for daily decision making. The MDS identified R1 demonstrated behavioral symptoms (i.e. hitting or scratching self, public sexual acts, screaming) during the review period; and the Care Area Assessment (CAA) for cognition and behavioral symptoms were listed as being triggered to be completed.

R1's care plan, last revised 5/5/20, identified R1 received mood stabilizing medication(s) and listed targeted behaviors which included anger, restlessness, disrobing in public and repeated statements. A series of goals were listed for R1 which included using less medications and having less than two reports of anxious verbalizations daily. The care plan listed several interventions to meet the established goals which included documenting the resident's behaviors and mood, intervening as needed, and providing 1:1 visits or reassurance to her when distressed.

R1's progress note, dated 10/28/19, identified R1 was being reviewed for a significant change in status assessment. A note was completed by registered nurse unit manager (RN)-B which identified, "Behavior: per the Target behavior charting crying was reported on 1 day. Verbally exhibiting anxiety was reported on 5 evenings with redirection and offering a snack or activity not being effective. Inability to sleep was reported X 5 days with reading material, TV, and snacks not being effective. Delusional comments reported daily with redirection and 1-1 visits no being effective. Exit seeking reported on 2 days

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2 830	Continued From page 19 with redirection and 1-1 not being effective." R1's subsequent progress note(s) were reviewed and identified the following: On 11/17/19, R1 had a verbal altercation with another resident. On 11/27/19, R1 was recorded as being, "...aggressive towards other residents this shift. Resident has increase [sic] anxiety, grand thoughts, and cursing. PRN [as needed] administered, which was somewhat effective." Further, on 12/7/19, R1 was attempted to go into other resident' rooms and when re-directed threw her coloring box on the floor and became upset. R1 was recorded as expiring on 1/16/20. R1's subsequent Target Behavior Monitoring flowsheets, dated 11/2019 to 1/2020, identified the following: November 2019: R1 had five episodes of exit seeking with each of the episodes having interventions completed, including coloring or taking off the unit, however, each time these interventions were recorded the behavior was recorded as, "Unchanged." R1 had six episodes of crying and/or weeping recorded with interventions completed, including reassurance and offering snacks or activities, however, each time these interventions were recorded the behavior was recorded as, "Unchanged." R1 had 10 episodes of verbal complaints of anxiety recorded with each of the episodes having interventions completed. However, again, all of these recorded episodes had the behaviors recorded as, "Unchanged," despite the interventions. R1 had 13 episodes of inability to sleep recorded, each having interventions listed which included massage, warm packs and snacks; however, again, all of these episodes recorded the behavior as, "Unchanged," despite	2 830		

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the interventions. Further, R1 had 22 episodes of delusional comments recorded with interventions being completed, including redirection and 1:1 visits, however each time these interventions were recorded the behavior was recorded as, "Unchanged."

December 2019: R1 had eight episodes of exit seeking with each of the episodes having interventions completed, including coloring or taking R1 off the unit, however, only one of the episodes was recorded as these interventions being effective. The other episodes recorded the behavior as, "Unchanged." R1 had one episode of crying and/or weeping recorded with interventions completed, including reassurance and offering snacks or activities, however, these interventions were not effective and the behavior was recorded as, "Unchanged." R1 had four episodes of verbal complaints of anxiety recorded with each of the episodes having interventions completed. However, again, all of these recorded episodes had the behaviors recorded as, "Unchanged," despite the interventions. R1 had seven episodes of inability to sleep recorded with each of the episodes having interventions completed which included massage, warm packs and snacks; however, again, all of these episodes recorded the behavior as, "Unchanged," despite the interventions. Further, R1 had 14 episodes of delusional comments recorded with interventions being completed, including redirection and 1:1 visits, however each time these interventions were recorded the behavior was recorded as, "Unchanged."

When interviewed on 7/16/20, at 10:17 a.m. nursing assistant (NA)-D voiced she recalled R1 and verified she resided on the Rum River Unit (locked memory care unit). R1 was able to

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self-propel in her wheelchair and often used, or attempted to use, other resident' bathrooms on the unit. NA-D recalled R1 had exit seeking behaviors and would often go around the unit "kicking, pounding on doors and swearing." NA-D expressed R1 was re-directable at times, and if not, the staff would give her medications which helped "most of the time." Further, NA-D stated any demonstrated behaviors from R1 were reported to the nurse(s) and added she felt R1's behaviors had gotten "maybe slightly worse" in the months leading up to her death in January 2020.

R1's medical record was reviewed and lacked evidence R1 had been comprehensively reassessed and new interventions developed to reduce R1's identified behaviors despite the behaviors, and implemented interventions, being recorded in the progress note(s) as not effective. Further, the medical record lacked any evidence a CAA had been completed for R5's cognition and behavioral symptoms despite being triggered on the 10/28/19 MDS (See F636 for additional information).

On 7/16/20, at 2:01 p.m. RN-B was interviewed and verified she was R1's care manager during the last months of her life at the nursing home. RN-B explained when a resident displays behavior(s), the staff attempt to observe the behavior and try to intervene by coming up with "things they like." The unit used to have behavior meetings which helped in this process, however, they had not had a meeting for "a few months" as other things took priority. RN-B stated the facility typically accomplished the behavioral assessment by discussing them "informally." On 7/17/20, at 9:08 a.m. a subsequent interview was held with RN-B. The last time R1 had been

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2 830	Continued From page 22 reviewed at the behavior meetings, at least to which RN-B could find evidence supporting, was in July 2019. They decided at the meeting to implement a "calming activities" intervention, however, RN-B voiced it had never been added to the care plan and should have been. Further, RN-B reviewed the medical record and verified there was no comprehensive assessment completed regarding R1's behaviors, despite the implemented interventions being listed as not effective and R1 continuing to have the same behaviors, and reiterated the system in place for assessing behaviors was the monthly meetings which had "fallen by the wayside." A provided Behavioral Health Services policy, dated 5/31/19, identified behavioral health encompasses a resident's whole emotional and mental well-being. The facility was to use " ... a comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care." This assessment included obtaining information from medical records, family and/or the resident on usual patterns of cognition or mood and behavior; and, using the Resident Assessment Instrument (RAI) process including the MDS and CAA(s). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures, inservice staff on identified needs and requirements, and then audit to ensure compliance with facility' policies regarding to resident supervision, outside clinic consultation and dementia care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		

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21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview, observation and document review the facility failed to ensure all employees were being actively screened (other employees verifying temperature readings during the screening process) for the prevention and potential transmission of corona virus (COVID-19), in accordance with the Centers for Disease Control (CDC) guidelines. This had the potential to affect all 92 residents currently residing in the facility at the time of the COVID-19 survey. Findings Include: A Centers for Medicare and Medicaid (CMS) COVID-19 Long-Term Care Facility Guidance, dated 4/2/20, identified procedures to be implemented to reduce the risk of COVID-19 transmission in a long-term care setting. This included, " ... every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked." On 7/17/20, at approximately 8:55 a.m. survey team entered facility through the main doors. At that time, survey staff observed three facility	21375	Corrected	8/25/20

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employees self screening with no verification of their temperature or COVID screening questions with another employee before entering the facility despite an employee being present at the screening table at the time (employee was screening survey staff).

When interviewed on 7/17/20, at 11:49 a.m. dietary aide (DA-A) stated when arriving to work she answered questions and took her own temperature. DA-A said, "There is always someone there to make sure you are doing the screening." DA-A stated she did not know of anyone "needing to check my temperature". DA-A stated again she self-administered her own temperature and documented the results in the symptoms section of the screening process.

When interviewed on 7/17/20, at 1:29 p.m. the director of nursing (DON) stated at the screening table there was always to be someone around to assist with the screening process. DON explained the screening process consisted of answering questions about symptoms and taking temperature. DON stated temperature monitoring was having "someone else" look at the temperature to verify result. DON stated there was a schedule for helping employees screen and someone was to be at the screening area to assist with all screening to verify information. DON stated she was not aware of employees not verifying temperatures. DON further explained employees had been educated on the screening process which included showing another employee verifying temperature results.

Policy entitled COVID-19 Phase 2-All SNFs and all CO sites states, "healthcare workers will complete a symptom screening form, including having their temperature checked .....these forms

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21375	Continued From page 25 will be reviewed by a facility designee prior to reporting to the resident care area". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could educate staff on active screening for COVID-19; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		