Electronically delivered
November 15, 2019

Administrator
MN Veterans Home Fergus Falls
1821 North Park
Fergus Falls, MN 56537

RE: CCN: 245636
Cycle Start Date: October 29, 2019

Dear Administrator:

On October 29, 2019, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 29, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 29, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245636	A. BUILDING _____ B. WING _____	C 10/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	**1821 NORTH PARK FERGUS FALLS, MN 56537**

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F 000	INITIAL COMMENTS On 10/29/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5636003C with F550 cited, along with associated tags of F609 and F610 for this complaint. H5636004C was substantiated with no deficiency cited, but associated tags were identified at F609 and F610 for this complaint. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		12/13/19

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

Electronically Signed | 11/20/2019

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

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dignified treatment for 1 of 1 residents (R1) who received unrequested perineum grooming and lacked	F 550	F550 □ Resident Rights/Exercise of Rights 1. Resident R1□s perineum area has	

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F 550	Continued From page 2 cognitive capacity to consent to this provision of care. Findings include: R1's annual Minimum Data Set (MDS) dated 8/22/19, identified R1 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia and diabetes mellitus. R1's MDS further identified R1 required extensive assistance with hygiene and total assistance with bathing. R1's care plan revised 9/6/19, identified R1 required extensive assitance with dressing, grooming, bathing, and hygiene related to her dementia and physically unable. R1's care plan identified R1 had a facial trimmer for when she had facial hair that needed trimming kept in the nurses cart. R1's care plan did not include direction to staff for perineum grooming. R1's medical record lacked documentation that R1 had received unrequesed perineum grooming. On 10/29/19, at 1:04 p.m. during observaiton, nursing assistant (NA)-A was in R1's room applying ceiling lift sling to R1. NA-A then transferred R1 to the bathroom, removed her slacks and brief, then lowered her to the toilet. NA-A indicated R1 had her pubic hair recently shaven, but did not know why. R1's pubic hair appeared to be recently shaven, with short stubbly hair. NA-A indicated she was not aware of any other residents who had received perineum grooming. On 10/29/19, at 1:46 p.m. NA-B indicated she had completed morning cares with R1, and noted	F 550	been monitored since it was shaved, and the area shows no signs of increased irritation. Resident R1 has shown no signs of having increased pain or discomfort to the area. Resident R1 s perineum area has not been shaved since the event outlined in the 2567. Other residents have been observed/assessed to not have had their perineum areas shaved. 2. All residents have the potential to be affected. 3. Director of Nursing and Administrator reviewed and revised policy titled Activities of Daily Living on 11/15/19. Facility staff will be educated by the Administrator or Designee regarding the Activities of Daily Living Policy by 12/13/19. 4. Audits will be conducted weekly for 4 weeks by the Director of Nursing or Designee for 5 random residents to ensure resident s care plan has been followed regarding resident s grooming preferences. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 12/13/19	

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F 550	Continued From page 3	F 550		

R1's pubic hair was shaven. NA-B indicated she had never seen another resident at the facility with their pubic hair shaven.

On 10/29/19, at 2:35 p.m. NA-C indicated she was made aware NA-D had shaven R1's pubic hair and it was a very big deal, and thought NA-D had been "written up". NA-C indicated she had figured out NA-D had shaven R1's pubic hair, because NA-D had given R1 a bath and had told her that day that she had shaved R1's arm pits. NA-C indicated NA-D stopped talking then, but did not tell her that she had shaven R1's pubic hair.

On 10/29/19, at 3:05 p.m. registered nurse (RN)-A indicated she had been working the day R1's received perineum grooming. RN-A indicated she was not working on R1's wing, and no one had brought it to her attention. RN-A indicated it was the next day or two that RN-D called and asked if I was aware who had shaven R1's pubic hair. RN-A indicated RN-D asked her because a nursing assistant had reported that she had noted R1's pubic hair was shaven the day before, when RN-A was working. RN-A indicated she had never heard any more about the incident.

On 10/29/19, at 3:26 p.m. administrator indicated the facility became aware of R1's pubic hair shaven by a nursing assistant on 10/13/19, which occurred on 10/12/19. Administrator indicated on 10/17/19, NA-D was interviewed by acting director of nursing (ADON) and NA-D had received disciplinary action due to not consulting with a nurse before providing perineum grooming to R1.

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F 550	Continued From page 4	F 550		

On 10/29/19, at 5:38 p.m. NA-E indicated she would not perform perineum grooming for a resident unless it was care planned. NA-E indicated she had never received training to shave a resident's pubic hair and thought it was odd to do so. NA-E indicated she had not seen any other residents with their perineum area shaven at the nursing home.

On 10/29/19, at 5:44 p.m. NA-F indicated she would not shave a resident's perineum area, and had never been trained to do so. NA-F indicated she observed it when she took care of R1 on 10/14/19, and reported it to RN-A right away. NA-F said RN-A was aware of it at that time.

On 10/29/19, at 5:13 p.m. RN-B indicated she was aware that R1's pubic hair had been shaven by a nursing assistant. RN-B confirmed it was not the usual facility practice to allow nursing assistants to shave resident's pubic hair and indicated the nursing assistant should check with the nurse first. RN-B confirmed it was not dignified and that it could be considered maltreatment due to being done in the resident's private area and R1 was cognitively impaired.

On 10/29/19, at 5:25 p.m. RN-C confirmed it was not the facility's usual practice to shave a pubic hair, "no, not at all'. RN-C indicated it would need to be ordered by a physician or requested by family. RN-C indicated she would never direct the unlicensed staff to shave a resident's pubic hair, or would not do it herself. RN-C confirmed it was not dignified care.

On 10/29/19, multiple unsuccessful attempts were made to contact NA-D by phone regarding her reason for shaving R1's perineal area.

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F 550	Continued From page 5 On 10/29/19, at 6:03 p.m. acting director of nursing (ADON) confirmed she was made aware of the incident on 10/13/19. ADON indicated she provided education and disciplinary action for NA-D regarding the incident. ADON indicated R1's family member (FM)-A was notified of the incident, as well as the nurse practitioner. ADON confirmed it was not a usual facility practice to provide perineum grooming for their residents. At 7:05 p.m. during follow up interview ADON indicated it would depend on the residents wishes, even if they were cognitively impaired, if it was or was not considered undignified care. ADON indicated it would depend on the residents wishes if she would expect a nursing assistant to shave a resdient's pubic hair, but then indicated no she would not. On 10/30/19, at 9:11 a.m. during a return phone call interview FM-A indicated he was informed that R1's pubic hair had been shaven by a nursing assistant. FM-A indicated the nurse who contacted him explained what had happened, and R1 had told him nothing about the incident. FM-A felt it turned out ok, since he was not aware of any problems from the incident. The facility policy titled Activities Of Daily Living (ADL), revised 5/2/18, identified the objective was to establish guidelines for implementation of rehab nursing programs in the areas of dressing, hygiene, grooming and eating. Resident functioning at their highest level of independence in basic self-cares will be promoted. Grooming/hygiene was identified to emphasis on appearance and dignity. The policy further identified changes in specific ADL areas would be reviewed and documented by licensed nurse.	F 550		

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F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an abuse policy that included all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the Administrator, State Agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within the required time frames. This deficient practice had the potential to affect all 102 residents residing in the facility. Findings include: Review of the facility's policy titled Vulnerable Adult/Resident Protection Plan effective date 5/2/19, included the following; - Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report the incident to their supervisor or the	F 607	F607 □ Develop/Implement Abuse/Neglect Policies 1. Administrator reviewed the federal regulation relating to F607 and trained social workers and nurse managers on the regulation on 11/6/19. 2. All residents have the potential to be affected. 3. Director of Nursing and Administrator reviewed and revised policy titled Vulnerable Adult/Resident Protection Plan on 11/19/19. Facility staff will be educated by the Administrator or Designee regarding the Vulnerable Adult/Resident Protection Plan Policy by 12/13/19. 4. Audits will be conducted weekly for 4 weeks by the Administrator or Designee for 10 random staff to ensure each staff member has a good understanding of the	12/13/19

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F 607	Continued From page 7 Officer of the Day (OD). That staff will then immediately ensure that the proper notifications are made to the facility leadership (i.ie Facility Administrator, Director of Nursing, Director of Social Services or designee) and state agency per state and federal requirements. -The following regarding therapeutic error must be considered when reporting is determined, included the following examples; -does not result in harm or injury... or if the injury or harm that required care did not result in substantial acute or chronic injury or illness, or permanent disability above and beyond the Vulnerable Adults's pre- existing condition. -is immediately reported and recorded internally in order to evaluate and identify corrective action -is sufficiently documented for review and evaluation -is not part of a pattern of errors by the individual -Elder Abuse Act: Reporting 2 hour limit identified: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but no later than 2 hours after forming the suspicion. All other reporting-within 24 hours-if the event that cause the reasonable suspicion does not result in serious bodily injury to a resident, the covered individual shall report the suspicion no later then 24 hours after forming the suspicion. The policies failed to include all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 607	Vulnerable Adult/Resident Protection Plan Policy. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 12/13/19	

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F 607	Continued From page 8 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 the State Survey Agency. On 10/29/19, at 3:26 p.m. administrator confirmed the facility's policy titled Vulnerable Adult/Resident Protection Plan effective date 5/2/19, was the facility's current policy. Administrator and surveyor reviewed content of the policy. Administrator confirmed the federal regulation reporting timelines were not included in the facility's current policy.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result 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	F 609		12/13/19

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F 609	Continued From page 9 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse were immediately reported to the State Agency (SA), no later than 2 hours after knowledge of the allegation of abuse, for 2 of 3 residents (R1, R2) reviewed for allegations of abuse. Findings include: R1's annual Minimum Data Set (MDS) dated 8/22/19, identified R1 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia and diabetes mellitus. R1's MDS further identified R1 required extensive assistance with hygiene and total assistance with bathing. R1's care plan revised 9/6/19, identified R1 required extensive assitance with dressing, grooming, bathing, and hygiene related to her dementia and physically unable. R1's care plan did not include direction to staff for perineum grooming. R1's medical record lacked documentation that R1 had received unrequesed perineum grooming.	F 609	F609 □ Reporting of Alleged Violations 1. Resident R1 and Resident R2 have been monitored by staff since the respective events outlined in the 2567. Resident R1□s perineum area has been monitored since it was shaved, and the area shows no signs of increased irritation. Resident R1 has shown no signs of having increased pain or discomfort to the area. Resident R1□s perineum area has not been shaved since the event outlined in the 2567. Resident R2 has been monitored for further sexual behaviors with nothing significant observed. Resident R4 passed away on 9/22/19. Facility has reported and will report other alleged incidents to OHFC. 2. All residents have the potential to be affected. 3. Director of Nursing and Administrator reviewed and revised policy titled Vulnerable Adult/Resident Protection Plan on 11/19/19. Facility staff will be educated by the Administrator or Designee regarding reporting timelines for incidents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245636	A. BUILDING _____ B. WING _____	C 10/29/2019

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F 609	Continued From page 10 The facility report titled Office Memorandum Investigation Report dated 10/22/19, identified the following: -a report was received on 10/13/19, that R1's pubic hair was shaven and was not apart of R1's usual grooming. R1's plan of care was not followed, and R1 was provided care/treatment that went beyond the scope of certified nursing assistant duties. -10/16/19, RN-D was interviewed and confirmed the incident was reported to her 10/13/19, by NA-H and NA-I that R1's pubic hair had been shaven. RN-D indicated NA-H and NA-I had thought they reported it to LPN-A on the morning of 10/12/19, and they thought R1 was shaven on 10/11/19. -10/16/19, LPN-A was interviewed and she indicated that she had been informed on 10/12/19, by NA-H and NA-I that R1 had her pubic hair shaven. LPN-A indicated she thought R1 had been shaven on 10/1/19, when she had a bath and had not completed a skin check on 10/11/19, due to R1 receiving a secondary bath, and skin checks were completed on resident's primary bath day. LPN-A had indicated she forgot to report it. -10/17/19, NA-D was interviewed, and admitted to shaving R1's pubic hair. NA-D said she felt R1's pubic hair did not look clean, and thought it hurt her, so proceeded to shave her. - acting director of nursing (ADON) statement identified she was notified on 10/13/19, by Administrator. Internal investigation and questions to resident to rule out harm or neglect was completed. The facility Office Memorandum Investigation Report, dated 10/22/19, failed to identify that the SA was notified of allegations of abuse, prior to	F 609	of potential abuse as well as the Vulnerable Adult/Resident Protection Plan Policy by 12/13/19. 4. Audits will be conducted weekly for 4 weeks by the Administrator or Designee for 10 random staff to ensure each staff member has a good understanding of the reporting timelines for incidents of potential abuse as well as the Vulnerable Adult/Resident Protection Plan Policy. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 12/13/19	

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F 609	Continued From page 11 the completion of an investigation. On 10/29/19, at 3:05 p.m. registered nurse (RN)-A indicated the usual facility process for reporting any allegations of abuse is to contact management as soon as possible, and management had time limits to report to the state agency. RN-A indicated she was called by RN-D 10/13/19, or 10/14/19, and asked if she was aware R1 had her pubic hair shaven on 10/12/19, when she was working. RN-A indicated RN-D was informed of the incident by a nursing assistant on 10/13/19. RN-A indicated she had not been made aware of the incident on 10/12/19, when she was working. On 10/29/19, at 3:26 p.m. administrator confirmed he had been informed on 10/13/19, that R1 had received unrequested perineum grooming by a nursing assistant on 10/12/19. Administrator indicated the facility had completed an investigation, but did not report it to the state agency, since they had not substantiated it as abuse or neglect. Administrator indicated during the investigation, which began on 10/13/19, he felt they had determined within 20 minutes that nursing assistant (NA)-D had shaven R1's pubic hair, but felt it not necessary to report the allegation of abuse. Administrator confirmed the ADON had not discussed the purpose of shaving R1's pubic hair until 10/17/19, when NA-D returned back to work, and determined that it was not maltreatment or abuse. Administrator indicated the facility followed the usual process to report allegations of abuse or neglect within 2 hours to the state agency. On 10/29/19, at 6:03 p.m. ADON indicated she	F 609		

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F 609	Continued From page 12	F 609		

was made aware of the incident by the administrator on the afternoon of 10/13/19. ADON indicated they discussed the findings with conversations the administrator had with nurses on 10/13/19, and it was discussed more on 10/14/19, when they developed a plan for the investigation. ADON indicated they had determined on 10/13/19, they did not suspect harm. ADON confirmed the first time she spoke to NA-D about shaving R1's pubic hair was on 10/17/19, when she had returned to work. ADON indicated based on R1's assessment and response they had determined it was not maltreatment or harm.

On 10/29/19, at 6:45 p.m. during follow up interview Administrator confirmed he was notified of the incident by phone on 10/13/19. Administrator indicated no one had alleged R1 had been assaulted, abused, injured or neglected. Administrator confirmed he had not made a report to the state agency for allegations of abuse, because he felt he did not have suspicion of abuse or neglect. Administrator indicated that he would have reported the incident, if RN-D had not found out any answers. Administrator confirmed NA-D who had shaven R1's pubic hair, was not interviewed until 10/17/19, 5 days after the incident occurred; but felt he had enough answers in that initial 2 hours, and in the initial 24 hours, that abuse or neglect had not occurred.

R2

R2's quarterly MDS dated 9/2/19, identified R2 had significant cognitive impairment and

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F 609	Continued From page 13	F 609		

diagnoses which included: post traumatic stress disorder (PTSD), hypertension and diabetes mellitus. R2's MDS further identified R2 required extensive assistance with all activities of daily living (ADLs)

R2's care plan revised 4/1/19, identified R1 had a history of touching female peer in a sexual manner. Interventions included; monitor interactions with other female residents due to history of being inappropriate, encourage R2 to keep a healthy distance, and to monitor and ensure that other female residents were safe.

R2's progress note dated 3/29/19, identified R2 had been observed rubbing R4's breast over her shirt. Staff separated R2 from R4 and staff were notified to keep them away from each other. R2 did not appear to understand what occurred but R4 indicated R2 had been bothering her because he was touching her breast. Director of Nursing (DON) was notified and nursing supervisor. R4's power of attorney was updated and attempt made to leave message with R2's family member. Progress note indicated would continue to monitor. R2's family member was attempted to be contacted and R4's POA was notified.

R2's incident report identified on 3/29/19, at 8:00 p.m. R2 was observed rubbing R4's breast. Staff separated R2 from R4 and 10 minutes later R4 was asked if R2 had bothered her, and R4 indicated yes, because R2 had grabbed her breast. The report identified the nursing supervisor and DON were notified. R2's family member had been contacted and updated and believed there was no harm, and R2 did not understand. R2 and R4 were to be kept separated and monitored.

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F 609	Continued From page 14	F 609		

The facility SA report reviewed identified the allegation of sexual abuse, sexual contact with lack of capacity to consent, occurred on 3/29/19, at 8:00 p.m. with R2 and R4. The SA report was submitted by the facility on 3/30/19, at 9:47 a.m., 13 hours after the incident occurred.

On 10/29/19, at 2:30 p.m. NA-C indicated she was aware R2 had touched a female resident's breast in the past. NA-C indicated the staff kept a close eye on him, and had not observed another incident since then.

On 10/29/19, at 5:31 p.m. RN-C confirmed she had been present when R2 touched the female resident's breast. RN-C indicated she had notified DON by phone within 15 minutes after the incident.

On 10/29/19, at 6:27 p.m. Administrator indicated R2's sexual abuse allegation was not substantiated by the faciltiy so it was not reported to the state agency within the required 2 hours, but was reported within 24 hours. Administrator indicated the facility had determined no harm, because the female resident showed no signs of fear, but he felt the facility needed to report the allegation to the state agency because of the seriousness of R2 inappropriately touching a female resident.

The facility's policy titled Vulnerable Adult/Resident Protection Plan effective date 5/2/19, identified any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report the incident to their supervisor or the Officer of the

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F 609	Continued From page 15 Day (OD). That staff will then immediately ensure that the proper notifications are made to the facility leadership (i.e. Facility Administrator, Director of Nursing, Director of Social Services or designee) and state agency per state and federal requirements.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 complete a thorough investigation to assure residents were safe, following an allegation of abuse, for 2 of 3 residents (R1, R2) investigated for abuse. Findings include; R1's annual Minimum Data Set (MDS) dated	F 610	F610 □ Investigate/Prevent/Correct Alleged Violation 1. Resident R1 and Resident R2 have been monitored by staff since the respective events outlined in the 2567. Resident R1□s perineum area has been monitored since it was shaved, and the area shows no signs of increased	12/13/19

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F 610	Continued From page 16 8/22/19, identified R1 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia and diabetes mellitus. R1's MDS further identified R1 required extensive assistance with hygiene and total assistance with bathing. R1's care plan revised 9/6/19, identified R1 required extensive assistance with dressing, grooming, bathing, and hygiene related to her dementia and physically unable. R1's care plan did not include direction to staff for perineum grooming R1's medical record was reviewed, and lacked any documentation of allegation of abuse, incident, or investigation, after the facility was notified R1 had received unrequested perineum grooming. The facility report titled Office Memorandum Investigation Report dated 10/22/19, identified the following: -a report was received on 10/13/19, that R1's pubic hair was shaven and was not apart of R1's usual grooming. R1's plan of care was not followed, and R1 was provided care/treatment that went beyond the scope of certified nursing assistant duties. -10/16/19, RN-D was interviewed and confirmed the incident was reported to her 10/13/19, by NA-H and NA-I that R1's pubic hair had been shaven. RN-D indicated NA-H and NA-I had thought they reported it to LPN-A on the morning of 10/12/19, and they thought R1 was shaven on 10/11/19. -10/16/19, LPN-A was interviewed and she indicated that she had been informed on 10/12/19, by NA-H and NA-I that R1 had her	F 610	irritation. Resident R1 has shown no signs of having increased pain or discomfort to the area. Resident R1 s perineum area has not been shaved since the event outlined in the 2567. Resident R2 has been monitored for further sexual behaviors with nothing significant observed. Resident R4 passed away on 9/22/19. Facility has investigated and will investigate other alleged incidents of potential abuse. Other residents have been observed/assessed to not have had their perineum areas shaved. Other residents have been interviewed and stated that they have not been touched inappropriately by any other residents and had not had their private area shaved by staff. 2. All residents have the potential to be affected. 3. Director of Nursing and Administrator reviewed and revised policy titled Vulnerable Adult/Resident Protection Plan on 11/19/19. Facility staff will be educated by the Administrator or Designee regarding conducting investigations into allegations of potential abuse as well as the Vulnerable Adult/Resident Protection Plan Policy by 12/13/19. 4. Audits will be conducted weekly for 4 weeks by the Administrator or Designee for 10 random staff to ensure each staff member has a good understanding of their role in our process for investigating allegations of potential abuse as well as the Vulnerable Adult/Resident Protection	

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F 610	Continued From page 17 pubic hair shaven. LPN-A indicated she thought R1 had been shaven on 10/1/19, when she had a bath and had not completed a skin check on 10/11/19, due to R1 receiving a secondary bath, and skin checks were completed on resident's primary bath day. LPN-A had indicated she forgot to report it. -10/17/19, NA-D was interviewed, and admitted to shaving R1's pubic hair. NA-D said she felt R1's pubic hair did not look clean, and thought it hurt her, so proceeded to shave her. - acting director of nursing (ADON) statement identified she was notified on 10/13/19, by Administrator. Internal investigation and questions to resident to rule out harm or neglect was completed. The facility Office Memorandum Investigation Report, dated 10/22/19, failed to identify a thorough, investigation was completed to protect other residents in the facility. On 10/29/19, at 1:04 p.m. nursing assistant (NA)-A was in R1's room applying ceiling lift sling to R1. NA-A then transferred R1 to the bathroom, removed her slacks and brief, then lowered her to the toilet. NA-A indicated R1 had her pubic hair recently shaven, but did not know why. R1's pubic hair appeared to be recently shaven, with short stubbly hair. NA-A indicated she was not aware of any other residents who had received perineum grooming. On 10/29/19, at 2:35 p.m. NA-C, indicated she was aware R1's pubic hair had been shaven a few weeks ago by NA-D. NA-C felt it was not done for bad intentions, and she felt NA-D may have thought R1 should be shaven to keep her cleaner. NA-C felt NA-D had shaven R1's pubic	F 610	Plan Policy. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 12/13/19	

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F 610	Continued From page 18	F 610		

hair, because she had given her a bath that day, and informed her that she had shaven R1's arm pits.

On 10/29/19, at 3:05 p.m. RN-A, indicated she was called on 10/13/19, or 10/14/19, by RN-A asking if she was aware R1 had her pubic hair shaven by a staff member. RN-A said she had worked that day, but had not been made aware of the incident. RN-A said she did not know if the facility had determined what happened, and indicated she had not heard anything more about the incident.

On 10/29/19, at 3:26 p.m. Administrator indicated the facility had completed an internal investigation regarding R1 receiving unrequested perineum grooming by a nursing assistant. Administrator confirmed the facility had not completed a report or documentation in R1's medical record.

ON 10/29/19, at 6:03 p.m. acting director of nursing (ADON) indicated she was made aware of the incident 10/13/19. ADON indicated she had discussed the findings with Administrator on 10/13/19, and 10/14/19, and they developed a plan for the investigation. ADON indicated as part of the investigation, she had interviewed RN-D and LPN-A who had worked that weekend, and NA-D when she returned to work on 10/17/19. ADON confirmed she had not interviewed any other staff members, or any residents during the investigation. ADON indicated the usual facility practice was not to interview other residents, for the discretion of the employee. ADON indicated if there was suspicion of abuse, they would have investigated differently.

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F 610	Continued From page 19 On 10/29/19, at 6:45 p.m. Administrator indicated he thought only three staff had been interviewed, and no residents were interviewed. Administrator indicated the facility would have been aware if any other residents had received unrequested perineum grooming, because of weekly skin inspections. Administrator indicated other residents were protected, because NA-D was off work until 10/17/19, when she returned to work, ADON talked to her about it and disciplinary action was provided. R2 R2's quarterly MDS dated 9/2/19, identified R2 had significant cognitive impairment and diagnoses which included: post traumatic stress disorder (PTSD), hypertension and diabetes mellitus. R2's MDS further identified R2 required extensive assistance with all activities of daily living (ADLs) R2's care plan revised 4/1/19, identified R1 had a history of touching female peer in a sexual manner. Interventions included; monitor interactions with other female residents due to history of being inappropriate, encourage R2 to keep a healthy distance, and to monitor and ensure that other female residents were safe. R2's progress note dated 3/29/19, identified R2 had been observed rubbing a female resident's breast over her shirt. Staff separated R2 from the female resident, and staff were notified to keep them away from each other. R2 did not appear to understand and the female resident indicated R2 had been bothering her because he was touching	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MN VETERANS HOME FERGUS FALLS	**1821 NORTH PARK FERGUS FALLS, MN 56537**

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F 610	Continued From page 20	F 610		

her breast. Director of Nursing (DON) was notified and nursing supervisor. Female resident's power of attorney was updated and attempt made to leave message with R2's family member (FM)-A. Progress note indicated would continue to monitor.

R2's incident report identified on 3/29/19, at 8:00 p.m. R2 was observed rubbing R4's breast. Staff separated R2 from R4 and 10 minutes later R4 was asked if R2 had bothered her, and R4 indicated yes, because R2 had grabbed her breast. The report identified the nursing supervisor and DON were notified. R2's family member had been contacted and updated and believed there was no harm, and R2 did not understand. R2 and R4 were to be kept separated and monitored.

The facility investigation submitted to SA provided by facility submitted 4/3/19, at 12:29 p.m. identified care plans and policy was followed. The investigation identified R2 and R4's care plans were both updated following the event. The investigation further identified RN-E was interviewed, who was notified of the event, LPN-A who was a witness and LPN-B. Details of interview were not included in the report.

The facility investigation failed to include a thorough investigation of the allegations of sexual abuse, and failed to include other staff and resident interviews were completed to assure other residents in the facility were safe.

On 10/29/19, at 5:31 p.m. RN-C indicated she was working when R2 had put his hand on a female resident's breast. RN-C said they separated R2 from the female resident right away

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(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 610	Continued From page 21	F 610		

then she had contacted the DON within 15 minutes.

On 10/29/19, at 6:15 p.m. ADON indicated she had not been part of the investigation of alleged sexual abuse by R2. ADON confirmed the total investigation was included in the incident and VA (vulnerable adult) report provided.

On 10/29/19, at 6:27 p.m. Administrator indicated a thorough investigation of the allegation of sexual abuse by R2 would include interview of the residents involved, any staff that witnessed it and review of their medical records. Administrator indicated he would also expect the staff to monitor the female resident to determine if she had any change in behavior, appearance of being scared, or she would not come out of her room after the incident. Administrator also indicated he would expect other residents to be protected by monitoring R2 after the incident to make sure not inappropriate sexual touch had not occurred between R2 and other female residents. Administrator stated other residents may also have needed to be interviewed, if they had witnessed what occurred but it would have depened on the situation.

The facility's policy titled Vulnerable Adult/Resident Protection Plan effective date 5/2/19, identified that all reports of abuse would be promptly and thoroughly investigated. Key elements of the investigation included obtaining resident statement or observations, resident roommate statement, involved staff and witnesses. The facility failed to include the possible need to obtain interviews of other residents and staff of other areas and shifts to determine if pattern of abuse was present and to

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F 610	Continued From page 22 protect the residents in the facility.	F 610		

Electronically Delivered

November 15, 2019

Administrator
MN Veterans Home Fergus Falls
1821 North Park
Fergus Falls, MN 56537

Re: State Nursing Home Licensing Orders - Complaint Numbers H5636003C, and H5636004C

Dear Administrator:

A complaint investigation was completed on October 29, 2019. At the time of the investigation, the surveyor assessed compliance with Minnesota Department of Health Nursing Home Rules. The surveyor from the Minnesota Department of Health noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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

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

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	C 10/29/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/29/19, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found not to be in compliance with the MN state licensure. The following complaint(s) were found to be	2 000		

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2 000	Continued From page 1 substantiated: H5636003C, H5636004C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dignified treatment for 1 of 1 residents (R1) who received unrequested perineum grooming and lacked cognitive capacity to consent to this provision of care. Findings include: R1's annual Minimum Data Set (MDS) dated 8/22/19, identified R1 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia and diabetes mellitus. R1's MDS further identified R1 required extensive assistance with hygiene and total assistance with bathing. R1's care plan revised 9/6/19, identified R1	21805	Not Required	12/13/19

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21805	Continued From page 2 required extensive assitance with dressing, grooming, bathing, and hygiene related to her dementia and physically unable. R1's care plan identified R1 had a facial trimmer for when she had facial hair that needed trimming kept in the nurses cart. R1's care plan did not include direction to staff for perineum grooming. R1's medical record lacked documentation that R1 had received unrequesed perineum grooming. On 10/29/19, at 1:04 p.m. during observaiton, nursing assistant (NA)-A was in R1's room applying ceiling lift sling to R1. NA-A then transferred R1 to the bathroom, removed her slacks and brief, then lowered her to the toilet. NA-A indicated R1 had her pubic hair recently shaven, but did not know why. R1's pubic hair appeared to be recently shaven, with short stubbly hair. NA-A indicated she was not aware of any other residents who had received perineum grooming. On 10/29/19, at 1:46 p.m. NA-B indicated she had completed morning cares with R1, and noted R1's pubic hair was shaven. NA-B indicated she had never seen another resident at the facility with their pubic hair shaven. On 10/29/19, at 2:35 p.m. NA-C indicated she was made aware NA-D had shaven R1's pubic hair and it was a very big deal, and thought NA-D had been "written up". NA-C indicated she had figured out NA-D had shaven R1's pubic hair, because NA-D had given R1 a bath and had told her that day that she had shaved R1's arm pits. NA-C indicated NA-D stopped talking then, but did not tell her that she had shaven R1's pubic hair.	21805		

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21805	Continued From page 3 On 10/29/19, at 3:05 p.m. registered nurse (RN)-A indicated she had been working the day R1's received perineum grooming. RN-A indicated she was not working on R1's wing, and no one had brought it to her attention. RN-A indicated it was the next day or two that RN-D called and asked if I was aware who had shaven R1's pubic hair. RN-A indicated RN-D asked her because a nursing assistant had reported that she had noted R1's pubic hair was shaven the day before, when RN-A was working. RN-A indicated she had never heard any more about the incident. On 10/29/19, at 3:26 p.m. administrator indicated the facility became aware of R1's pubic hair shaven by a nursing assistant on 10/13/19, which occurred on 10/12/19. Administrator indicated on 10/17/19, NA-D was interviewed by acting director of nursing (ADON) and NA-D had received disciplinary action due to not consulting with a nurse before providing perineum grooming to R1. On 10/29/19, at 5:38 p.m. NA-E indicated she would not perform perineum grooming for a resident unless it was care planned. NA-E indicated she had never received training to shave a resident's pubic hair and thought it was odd to do so. NA-E indicated she had not seen any other residents with their perineum area shaven at the nursing home. On 10/29/19, at 5:44 p.m. NA-F indicated she would not shave a resident's perineum area, and had never been trained to do so. NA-F indicated she observed it when she took care of R1 on 10/14/19, and reported it to RN-A right away. NA-F said RN-A was aware of it at that time.	21805		

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21805	Continued From page 4 On 10/29/19, at 5:13 p.m. RN-B indicated she was aware that R1's pubic hair had been shaven by a nursing assistant. RN-B confirmed it was not the usual facility practice to allow nursing assistants to shave resident's pubic hair and indicated the nursing assistant should check with the nurse first. RN-B confirmed it was not dignified and that it could be considered maltreatment due to being done in the resident's private area and R1 was cognitively impaired. On 10/29/19, at 5:25 p.m. RN-C confirmed it was not the facility's usual practice to shave a pubic hair, "no, not at all'. RN-C indicated it would need to be ordered by a physician or requested by family. RN-C indicated she would never direct the unlicensed staff to shave a resident's pubic hair, or would not do it herself. RN-C confirmed it was not dignified care. On 10/29/19, multiple unsuccessful attempts were made to contact NA-D by phone regarding her reason for shaving R1's perineal area. On 10/29/19, at 6:03 p.m. acting director of nursing (ADON) confirmed she was made aware of the incident on 10/13/19. ADON indicated she provided education and disciplinary action for NA-D regarding the incident. ADON indicated R1's family member (FM)-A was notified of the incident, as well as the nurse practitioner. ADON confirmed it was not a usual facility practice to provide perineum grooming for their residents. At 7:05 p.m. during follow up interview ADON indicated it would depend on the residents wishes, even if they were cognitively impaired, if it was or was not considered undignified care. ADON indicated it would depend on the residents wishes if she would expect a nursing assistant to shave a resdient's pubic hair, but then indicated	21805		

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21805	Continued From page 5 no she would not. On 10/30/19, at 9:11 a.m. during a return phone call interview FM-A indicated he was informed that R1's pubic hair had been shaven by a nursing assistant. FM-A indicated the nurse who contacted him explained what had happened, and R1 had told him nothing about the incident. FM-A felt it turned out ok, since he was not aware of any problems from the incident. The facility policy titled Activities Of Daily Living (ADL), revised 5/2/18, identified the objective was to establish guidelines for implementation of rehab nursing programs in the areas of dressing, hygiene, grooming and eating. Resident functioning at their highest level of independence in basic self-cares will be promoted. Grooming/hygiene was identified to emphasis on appearance and dignity. The policy further identified changes in specific ADL areas would be reviewed and documented by licensed nurse. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents did not receive perineal shaving if not desired. TIME PERIOD FOR CORRECTION: Twnety-one (21) days	21805		