STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORRIS SQUARE	6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to complete a psychosocial assessment, implement safety measures, and notify appropriate parties for 1 of 1 residents (R1) who stated she wanted to kill herself with scissors she had in her possession, then cut her wrists with a butter knife and was transported to the hospital. The lack of facility assessment and implementation of safety measure, placed R1 in immediate jeopardy. The immediate jeopardy began on 7/1/20, at 5:00 p.m. when the facility failed to assess R1's psychological needs, and implement immediate safety measures after R1 threatened to kill herself with a scissors. The administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) on 7/14/20 at 4:00 p.m. The IJ was removed on 7/15/20, at 11:38 a.m. but noncompliance remained at the lower scope and severity level of a D- isolated incident with no actual harm with potential for more than minimal harm. Findings include: R1's entry Minimum Data Set (MDS), dated [DATE], indicated an admission from the community on 7/1/20. R1's MDS, dated [DATE], included R1 had been discharged to a hospital on [DATE]. R1's care plan dated 7/1/20, included, I have an alteration in mood or behavioral expression. R1's goal was, I will demonstrate effective coping skills through the review date. R1's interventions directed staff, Encourage me to participate in activities of interest. Explain all procedures to me. Intervene as necessary to protect the rights of others. Approach/Speak in a calm manner. Divert attention. Remove me from the situation and take me to an alternate location as needed. The care plan listed [DIAGNOSES REDACTED]. R1's body audit, dated 7/1/20, indicated R1 did not have any scratches, cuts or skin tears. R1's Brief Interview for Mental Status, [MEDICAL CONDITION] and Communication assessment, dated 7/2/20, indicated R1 had moderately impaired cognition. R1's incident report dated 7/2/20, at 2:30 p.m. included, Resident Services Director entered residents room around 2:30 pm to do initial assessment. Resident admitted to this facility on 7/1/2020 at 10:00 AM. Resident was sitting in her chair listening to her radio with her lunch in front of her, untouched. Resident Services Director noticed resident was holding a butter knife from lunch. Writer kept an eye on it, and as writer started talking with resident, res (resident) turned over her right wrist and started cutting herself with the knife. There was already a red mark on her wrist and started cutting herself with the knife. Writer asked what she was doing, and resident started to cry. Writer asked if she could have the knife and resident handed it over right away. Resident then stated, 'I just want to die.' Resident service director stayed with resident and texted nursing staff for assistance. Resident Service Director informed by nursing to stay with resident on 1:1 (one on one) until a safe plan could be made. Resident assessed and had superficial abrasions to right wrist. NP (nurse practitioner), Family updated and 911 called. Resident transferred to United Hospital via EMT (emergency medical transport). Information provided to this facility prior to resident being admitted there was no indication of prior attempts of resident trying to harm self. After resident admitted to this facility she did not voice any concerns with self harm and there were no indications that resident would self harm. Internal investigation started and all parties notified. R1's progress note dated 7/2/20, at 1 :07 a.m. indicated R1 was agitated and restless early in the shift and wanted to go to the bathroom right away. The progress note further indicated R1 pretended to take her medications, but would hide medication in her pocket and was educated about the risk of not taking medications. However, the note failed to include any attempt to find out why R1 did not want to take the medication or source of her agitation. R1's progress note dated 7/2/20, at 8:09 a.m. included, Yelling out taking off her oxygen. Writer approached resident to see how she could be helped. Resident had her phone, her call light her oxygen and her radio all in her left hand with lines twisted. Resident had walking cane in right hand. As writer approached resident swung cane in direction of writer. Writer grabbed cane to stop cane from hitting writer. Resident stated that she didn't mean to hit writer and began to calm down. Writer untangled all the cords and organized room, placed 02 (oxygen) back on resident. Offered PRN (as needed) lorazapem for anxiety but resident refused. Attempted to give AM medications but resident stated that it was too early for that. Was then making statements like, 'Why are you guys so nice to me?' but then would say 'I know you're going to kill me.' Then asked writer to call family member (F-A). Writer called (F-A) and left resident alone, letting her know that writer would be back after breakfast for her morning medications. The note failed to include an assessment of R1's distress. R1's progress note dated 7/2/20, at 10:34 a.m. included, Continues to make statements thinking the staff are going to kill her. Reassured resident that staff was not going to kill her and that she was safe. The progress note failed to include any assessment of R1's distress. R1's progress note dated 7/2/20, at 2:42 p.m. included, Nurse manager states that resident is going to the hospital because she was seen trying to cut herself with a knife. No puncture noted to wrist. All sharp objects collected from room and placed in nurse managers office. R1's progress note written by social services director (SSD) on 7/2/20, 4:14 p.m. included, Writer entered room around 2:30 pm to do initial assessments. Resident was sitting in her chair listening to her radio with her lunch in front of her, untouched. Writer noticed resident was holding her knife from lunch. Writer kept an eye on it, and as writer started talking with resident, res (resident) turned over her right wrist and started cutting herself with the knife. There was already a red mark on her wrist, making it appear that she had been doing this prior to writer entering her room. Writer asked what she was doing, and resident started to cry. Writer asked If she could have the knife and resident handed it over right away. Resident then stated: 'I just want to die. My (family member) says that I lie. That I just sit here and make things up, but I don't. I don't do that. I'm blind. I can't do anything. I'm better off dead. (family member) blames me for everything.' Writer told resident that she was here to listen. Resident talked about how her (family member) has a lot on (family member's) plate as (family member) is responsible for a (another family member) as well. Resident stated, 'my (family member) takes everything out on me.' She stated that she broke her phone after the phone call with her (family member) earlier this afternoon. She said, 'I shouldn't have done that. Now I don't have a phone.' and was very tearful. Writer reassured resident that staff can get her a new phone. Resident also told writer that she is scared because she can't see, and she has anxiety. Resident stated she does not have a plan in place to kill herself, and that this is the first time she has done something like this. She asked writer not to say anything to anyone about her wrist. Writer explained that she has to tell the nursing staff so they can help her and that she will be going to the hospital, as 911 was already called. Writer sat with resident talking with her until ambulance arrived to take her to the hospital. She had significant changes in behavior during that time, from happy and talking about her (family member) and how she enjoyed sewing, to very tearful and upset talking about the conversation she had with her (family member) this afternoon. Resident was transported to United Hospital per (family member's) recommendation. R1's progress note, dated 7/7/20, at 3:58 p.m. included, On Wednesday July 1st at around 5:00 pm, I have got report that, the patient hid the Caesar (sic) in her shoe. Patient said I want to kill myself. I gave sometime to patient and asked if I can help her, patient asked me if I can call her (family member, F-A), I promised her to call her (F-A) and J (sic) asked her to give me the caesar (sic) and she gave to me. I put the Caesar (sic) away from patient and called her (F-A). after pt (patient)

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

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) talked to her (F-A), pt was happy and not showed such behavior. Nurse told aid to watch the pt and report if any behavior repeated. R1's Investigation Summary, dated 7/8/20, included, R1 had a previous incident on 7/1/20, at 5:00 p.m., Resident had two pairs of scissors. Resident Assistant (RA) asked resident what she was doing with the scissors and resident stated she was going to kill herself with them. The RA notified a nurse and R1 repeated to the nurse she was going to kill herself. The nurse listened to R1 and R1 did hand the scissors to the nurse. The nurse placed the scissors in the resident's drawer which was still accessible to R1.After resident left facility in anticipation of residents return, a room sweep was performed to identify any objects that resident could self-harm with and they were removed including the scissors. The nurse on duty that found the scissors received written corrective action to be placed in personnel file and re-educated on Threats to Harm Self and Prevention Policy and expectations to follow the policy. All other staff to be re-educated on Threats to Harm Self and Prevention Policy. When interviewed on 7/13/20, at 1:30 p.m. licensed practical nurse (LPN)-A stated she had not heard about any incident with R1 and had not received any recent training on residents at risk for self-harm. She had worked with R1 on 7/1/20 and noted agitated behaviors. When interviewed on 7/13/20, at 1:45 p.m. NA-E stated he worked with R1 on the morning of 7/2/20. NA-E heard R1 screaming and yelling at 6:00 a.m. NA-E attempted to assist R1, but she struck him with her cane. NA-E reported R1's agitation to RN-H. When interviewed on 7/13/20, at 1:55 p.m. RN-D stated when he had arrived at work on 7/2/20, he found a pair of scissors on R1's dresser, but was not aware that R1 had threatened to harm herself with those scissors and did not remove them. R1 was then left alone in the room without being monitored. RN-H later removed the scissors from the dresser, but RN-D did not know what time this was. When interviewed on 7/13/20, at 3:13 p.m. the SSD had found R1 with the butter knife on 7/2/20, and stayed with R1 while awaiting transport to the hospital. SSD had not had any prior training at the facility on how to respond to residents with threats of self-harm, but had notified nursing and stayed with R1 as described in the incident report. The SSD stated she completed a Threats to Self Harm Assessment on 7/2/20, while waiting for the ambulance. R1's Threats to Self Harm assessment dated [DATE], included, Resident was using her knife from lunch to cut her right wrist during visit with writer this afternoon. Resident stated she just wanted to die and was very upset after a phone conversation with her daughter. Resident is on medication for anxiety and depression. She stated that she is scared because she cannot see and is in a new environment She also told writer she has never done anything like this to herself before. Writer stayed with resident until the ambulance arrived to transport her to the hospital. When interviewed on 7/13/20, at 3:29 p.m. nursing assistant (NA)-D stated he had worked with R1 on 7/1/20, and had answered her call light around 5:00 p.m. R1 had a scissors in her hand and reported she had another scissors up her sleeve. NA-D asked R1 for the scissors and R1 refused to give them to him. R1 stated she was going to kill herself with the scissors. NA-D reported this immediately to RN-I. R1 gave the scissors to RN-I. When interviewed on 7/13/20, at 4:08 p.m. RN-I stated on 7/1/20, around 5:00 p.m. NA-D notified her R1 had a pair of scissors and stated she was going to kill herself with them. RN-I was able to get the scissors from R1 and placed them on top of R1's dresser in her room. RN-I stated she did a body assessment to ensure R1 did not injure herself. RN-I left the room and when she returned R1 was on the phone with a family member. RN-I did not complete a comprehensive assessment of R1's suicide risk, did not notify the physician or family member and did not report this incident to a manager, director of nursing, or social services. RN-I also did not place any interventions to ensure R1 did not harm self, such as removing any sharp objects or cords, (including the scissors) from R1's access or place any other interventions to protect R1. RN-I had not documented the incident that occurred on 7/1/20, until directed to on 7/7/20. When interviewed on 7/13/20, at 4:24 p.m. family member (FM)-A stated, R1 was upset when they spoke on 7/1/20, and R1 stated, 'You don't know what they are trying to do - you don't know you don't know they are trying to hurt me.' FM-A indicated they had not been made aware R1 had scissors in her room, and the facility only called FM-A to tell them when R1 was on the way to the hospital. FM-A stated the facility told them R1 had a butter knife and tried to kill herself. FM-A stated if the facility had called and told them R1 had scissors and threatened to kill herself the day before, family would have come to calm her down and see what they could do to get her help and prevent self-harm. However, this information had never been relayed to them until R1 was on the way to the hospital after the second incident. When interviewed on 7/13/20, at 2:55 p.m. RN-A stated they had not worked with R1. RN-A had training via Relias, which is an online training, about challenging behaviors and communication with people with dementia when hired. However, no specific training on self-harm or suicidal ideation's in the past couple weeks. When interviewed on 7/13/20, at 3:13 p.m. NA-A stated they had not received any training in the past couple weeks on self-harm or suicidal ideation's. When interviewed on 7/13/20, at 3:34 p.m. NA-B indicated she did not have training on working with residents with self-harm concerns or suicidal ideation. When interviewed on 7/14/20, at 11:28 a.m. RN-H stated the morning of 7/2/20, R1 was yelling and hitting the walls with her cane and attempted to hit staff also. RN-H stated she asked R1 to stop doing that. She found scissors on top of R1's dresser and removed those and some pushpins from the cork board. RN-H stated she let the director of nursing (DON) know she had removed sharp objects from R1's room. She had removed them due to fear of R1 hurting staff with them, and was not aware at that time that R1 had threatened to kill herself with those scissors. On 7/14/20, at 11:44 a.m. housekeeper (H)-A reported she had not recently reviewed what to do if a resident threatened self harm. H-A reported she would probably tell the resident not to do it, take the object away from the resident and push the call light for a nurse. H-A reported there was not a system in which resident safety precautions were communicated to her. H-A stated she thought the nursing assistant might tell her if there were precautions. When interviewed on 7/14/20, at 12:11 p.m. NA-F stated she had just received some training today on how to manage self-harm behaviors, by reading some information and signing a form. When interviewed on 7/14/20, at 1:27 a.m. the DON stated, RN-H had reported on 7/2/20 that R1 was striking out at staff with her cane and had removed some sharp objects from her room. The DON had not been aware of the 7/1/20 incident with the scissors until after starting to investigate the 7/2/20, incident with the butter knife. The DON stated for the 7/1/20, incident RN-I should have assessed R1 for self harm, remove the two pairs of scissors, not leave alone, and notify the practitioner, all which were not done. RN-I had received disciplinary notice and training. When interviewed on 7/14/20, at 11:45 a.m. dietary aide (DA)-C stated they had worked the day R1 was sent to the hospital. DA-C was not aware of any concern about R1 having any sharp utensils. This was not relayed to dietary staff. If DA-C had been aware, they would have provided plastic utensils rather than a regular butter knife and would have known to cut up food for R1. DA-C stated if a resident should not have sharp objects such as knives or glassware, it should be noted on their dietary card. DA-C had never received any training from the facility on what to do if someone threatened suicide or self-harm. When interviewed on 7/14/20, at 11:20 a.m. DA-B stated that last week they were given a sheet to read on signs to watch for if someone was at risk of harming themselves, but had not received any training. They had to sign that they read the sheet. DA-B stated she doesn't know how dietary would be informed if someone wanted to harm themselves and wanted to ask, but didn't know who to ask follow up questions to. When interviewed on 7/14/20, at 11:22 a.m. DA-A indicated she did not have training on working with residents with self-harm concerns or suicidal ideation, but last week they had to read and sign sheet on what signs to watch for. DA-A indicated supervisory staff should let them know if a resident has any precautions related to self-harm or special dinging service needs. DA-A also stated she didn't think dietary staff could know about suicidal tendencies in a resident because that was a, HIPPA (Health Insurance Portability and Accountability Act) thing. DA-A indicated dietary staff were told not to enter R1's room because R1 had hit an aide with her cane. Dietary staff were not given any instruction to withhold items such as knives or sharp objects from R1's meal tray. When interviewed on 7/14/20, at 11:45 a.m. the director of dietary services (DDS) indicated there should be dining precautions in place for residents identified with risk for self-harm including only giving them plastics, and not giving glass or something that would break. The DDS also indicated that they would also give a lighter weight plastic silverware, and a plastic knife only if needed. The DDS indicated they did not know what happened in R1's case, and they would have to check with staff to verify the communication break down. DDS stated if we had known the issue, they would have only provided disposable plastic. When interviewed on 7/14/20, at 11:50 a.m. RN-G stated that when R1 was threatening to kill herself on 7/1/20, RN-I should have followed their procedure which was to notify the clinical coordinator and director of nursing (DON), call 911, and not leave the resident alone. Staff should have removed all objects residents could use to harm themselves and make sure the resident was safe. Dietary should have notified not to provide any objects that could be used to harm oneself if at risk. R1 should have been assessed for self-harm and immediate interventions should have been placed. RN-G stated since the facility is so new and self-harm or suicidal ideation's had never come up before, they had not done any specific training on this for staff. However, there was a Relias annual training on vulnerable adult requirements, observing and reporting. When interviewed on 7/14/20, at 12:28 p.m. NA-C indicated she did not receive on-site training on working with residents with self-harm concerns or suicidal ideation and stated, We do an annual Relias training but I did not receive any education here. I would definitely try to find a

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) supervisor or a nurse, talk to the resident to determine what to do best, especially if felt the person was going to actively do it in the minutes that I was there, would not leave the person alone, would look for sharp objects, remove call clip or any kind of cord or anything they could harm themselves, get it totally out of the room. When interviewed on 7/14/20, at 12:35 p.m. RN-C indicated she did not receive training on working with residents with self-harm concerns or suicidal ideation in the last couple weeks. A facility education entitled Guidelines for Handling Suicide Threats Policy and Threats to Harm Self and Prevention Policy had a document to sign indicating staff had received training on this. Staff who had worked since the 7/2/20, incident with R1, but had as of 7/14/20, at 12:49 p.m. yet to receive the training included: RN-A, RN-B, RN-C, RN-E, RN-F, NA-A, NA-B, NA-C, NA-D, NA-F, PT-A, DA-C. This was verified by the administrator. The facilities Guidelines for Handling Suicide Threats Policy, reviewed 2/16, indicated: 1. All suicide threats will be taken seriously and evaluated based on what is known and observed/assessed regarding the resident/client and what the physician recommends. 2. If a resident/client threatens suicide, designate a staff person to stay with him or her while the nurse is notified. 3. The nurse will notify the social worker or designee to assist in assessment and include a psychologist or psychiatrist as available. 4. The nurse will notify the family and physician promptly a recommendation for psych services will be reviewed with the physician and family for consideration of either inpatient geri-psych services or in-house referral. 5. Remove as many potentially lethal instruments from the room as possible, including medications, razors, tableware, nail files, glass, neckties, and panty hose. 6. Obtain direction from physician regarding psychiatric consultation, transfer to hospital, medication. Note that if suicidal threats are made, medication alterations may take an extended amount of time to reach full effectiveness. Therefore, if an identified plan threat is known admission to an inpatient setting should be strongly considered. 7. If satisfying direction has not been received for the physician and/or if any subsequent unmanageable suicide threats are made, and/or if you feel that the resident/client's mental condition renders him/her dangerous to self, call 911. 8. Take time to talk to the resident/client. See questions to ask a potentially suicidal resident/client. 9. Assure that sufficient observation and assessment is scheduled around the clock to reduce the chance of self injury. See guidelines for assessing suicide risk to determine frequency of monitoring. 10. If after repetitive suicidal ideation's or the need for 1:1 supervision, it becomes evident that the facility cannot provide adequate supervision and safety of the resident or others, the interdisciplinary team in partnership with the physician and psych services should consider alternate placement. 11. In the event that the resident is determined to need continuous observation until a longer term plan is implemented or emergency personnel are summoned, 1:1 supervision or indirect supervision through video observation may be used as indicated and compliant with appropriate consents and HIPPA requirements. The immediate jeopardy that began on 7/1/20, was removed on 7/15/20, when the facility reviewed their policies/procedures and ensured all staff would be trained in how to manage residents who may be at risk of harming themselves, prior to beginning their next shift. However, the noncompliance remained at the lower scope and severity level of a D- isolated incident with no actual harm with potential for more than minimal harm.