STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GARDENS AT CANNON FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009

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

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to thoroughly investigate and/or provide protection following allegations of neglect/abuse for 6 of 6 resident's (R5, R6, R3, R4, R1, and R2) reviewed for abuse allegations. Findings include: R5's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R5 was cognitively intact and required total assistance with bed mobility, transfer, dressing, eating, toileting and personal hygiene. R5 required supervision after set up for locomotion on the unit. R6's annual MDS dated [DATE], indicated R6 was cognitively intact. Furthermore, R6 was independent with bed mobility, transfer, eating, toileting and personal hygiene. R6 required set up for dressing. A police report dated 2/29/20, described an incident where R6 held a closed fist in R5's face, threatening him. R6 also threatened to tip R5 over in his wheelchair. A facility incident report dated 2/29/20, at 4:57 p.m. indicated R5 and R6 were in a verbal and threatening altercation. The police were called. The incident was unwitnessed by staff. R5 and R6 admitted to verbal and threatening insults. A facility incident report dated 3/4/20, at 6:30 p.m., indicated R5 spoke with the facility administrator on 3/4/20, and reported feeling vulnerable since the incident on 2/29/20, and was worried R6 would come in his room and hurt him. R5's care plan (CP) printed 3/6/20, was not updated to reflect the complaint of abuse on 2/29/20, for resident to resident altercation. On 3/4/20, the CP was updated to show 15 minute safety checks were implemented. The CP lacked rationale for the 15 minute checks. R6's CP printed [DATE], lacked documentation of the complaint of abuse on 2/29/20, for resident to resident altercation. R5 was observed on 3/9/20, at 12:54 p.m. lying in bed. When interviewed, R5 stated due to a [DIAGNOSES REDACTED]. R5 stated after the verbal abuse and threat from R6 on 2/29/20, he felt unsafe. R5 stated there was nothing stopping R6 from coming into R5's room because staff were not watching for this. R5 was still worried R6 would retaliate after the incident on 2/29/20. R5 stated the facility called the police when the incident happened but did not know of any other follow up, Staff did nothing after it to protect me. R5 stated he talked to the administrator about his feelings of vulnerability on 3/4/20. During interview on 3/9/20, at 1:54 p.m. nursing assistant (NA)-I reported having worked with R5 the weekend of 2/29/20. NA-I stated the 15 minute checks were not in place that weekend. NA-I did not recall being interviewed about the incident on 2/29/20. R6 was interviewed on 3/9/20, at 2:09 p.m. R6 stated R5 had a history of [REDACTED]. R6 stated since the verbal altercation happened on 2/29/20, he had not said anything else to R5 and did not plan to. R6 stated the director of nursing (DON) had talked to him at some point (unsure of when) and said there can be, no more fighting otherwise they will take chairs away from the visiting area. During interview on 3/9/20, at 2:11 p.m. nursing assistant NA-E, and NA-G stated they were assigned to work on R5 and R6's hallways today. They reported being unaware of any incidents between R5 and R6. They reported being unaware of what R5's current 15 minute checks were for. During interview on 3/9/20, at 2:31 p.m. registered nurse (RN)-D stated she was the charge nurse on 2/29/20, and had called the police after being made aware of the verbal altercation. RN-D said she hadn't initiated interviews, ongoing monitoring or 15 minute checks after the incident. RN-D recalled talking to R5 about the incident but not R6. During interview on [DATE], at 9:17 a.m. social worker (SW) stated she had spoken to R6 and R5 on 3/2/20 and 3/3/20, respectively, about the incident on 2/29/20. SW reported she asked R6 to stay off the hallway R5 lived on. SW stated R6 had a drinking (ETOH) problem and if it got out of control R6 knew he would have to potentially find a new place to live. SW agreed the medical records lacked evidence of the discussion. SW stated there were no further interviews completed with other residents or staff. On [DATE], at 9:32 a.m., R6 was observed to be walking down the hallway R5 resided on. R6 sat down to visit with a resident a couple rooms away from R5's room. During interview with the unit manager registered nurse, RN-E on [DATE] at 11:00 a.m. RN-E stated after a resident to resident altercation the expectation would be to ensure the residents feel safe, do 15 min safety checks, interview, update care plan and follow up. RN-E stated she had not talked to R5 or R6 about the incident. RN-E stated the floor nurses should have reported to oncoming staff about incidents and the rationale when 15 minute checks had been implemented. During interview with the director of nursing (DON) on [DATE], at 12:18 p.m. the DON stated the expectation following an incident of abuse would be to complete interviews based on the policy. DON was unable to comment regarding why the medical records lacked evidence that protection, continued observations and monitoring of the units was implemented. DON stated further interviews were not initiated after the incident because the police came and both residents went to their own rooms. R3's quarterly MDS dated [DATE], indicated R3 was assessed as cognitively intact and required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene assistance. R3's CP dated 12/8/19, indicated R3 had a current ADL (activities of daily living) self-care performance deficit related to pain associated with [MEDICAL CONDITION] with a current pathological fracture, weakness, and end of life cares with current decline in health status. The interventions directed extensive assist of one with cares for bathing/showering, bed mobility, dressing, toilet use and personal hygiene. A facility incident report dated 2/10/20, at 7:40 p.m. read, (R3) reported to (licensed practical nurse, (LPN-C) that she had a terrible night because the aide was not nice. She said her legs were between the bed and floor mat in the crack and she couldn't sleep. She asked the aide to cover her feet and the aide threw the blankets on her stomach. R3's CP did not address a vulnerability plan for abuse and was not updated to reflect a complaint of abuse for neglect of care on 2/10/20. R3 was observed on 3/9/20, at 1:29 p.m. sitting up in the wheel chair next to the bed. When interviewed, R3 stated, They do not come in to help me at night, I could have the call light on all night long, then, other times I have woken and someone is standing over me, I feel afraid when that happens. I know they do not come to help me many times but I hear them in the hallway laughing, yet they won't answer my call light. I even had a guy throw me into the bed and walked out the door, it makes you feel pretty useless. R3 did not recall the specific details on 2/10/20, with NA-A but stated, That aide (NA-A) was not nice to me and I told them she refused to help me. During an investigation of a complaint of neglect of care for R3, the facility interviewed other resident's and R4 expressed neglect of care by another different staff person NA-B on the night shift. R4's quarterly MDS dated [DATE], indicated R4 had severe cognitive impairment and required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene assistance. R4's CP dated 7/23/19, indicated an impaired cognitive function related to intellectual disabilities resulting in impaired decision making skills and neurological symptoms. R4's CP dated 7/23/19, indicated R4 had an ADL self-care performance deficit related to impaired balance, limited mobility due to early-onset cerebellar ataxia (loss of full control of bodily movements), and intellectual disabilities. R4's CP dated 7/23/19, indicated R4 required a toileting schedule every three hours and to offer the toilet and transfer with the easy stand (mechanical device). Notify the nurse during the night if she refuses, and offer to check and change if incontinent. R4's CP did not address a vulnerability plan for abuse and was not updated to reflect a complaint for neglect of care on 2/10/20. R4's incident report dated 2/10/20, at 7:40 p.m. indicated (NA-B) was argumentative during cares. R4 indicated wanting to get up at midnight and was told no by (NA-B). R1's quarterly MDS dated [DATE], indicated R1 was assessed as cognitively intact and required limited staff assistance with bed mobility, transfer, walking in the room and corridor, locomotion on and off the unit, dressing, toilet use and personal

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) hygiene assistance. R1's CP dated 1/2/20, indicated R1 had an ADL self-care deficit related to [MEDICAL CONDITIONS], compression fractures and generalized weakness. The interventions directed extensive assist of one with cares for bathing/showering, bed mobility, dressing, personal hygiene, toilet use and transfer. R1's document review of a facility reported incident to the State Agency submitted 2/23/20, at 1:12 p.m. indicated NA-A was argumentative during cares. R1 indicated NA-A came into the bedroom around 5:00 a.m. and was, rude and confrontational. R1 wanted to be up early for breakfast due to an appointment and NA-A, started to yell, 'I am not putting up with this,' and walked out. According to the document R1 had requested help from NA-A, many times during the night for peri cares and NA-A, refused. R1's CP did not address a vulnerability plan for abuse and was not updated to reflect a complaint of neglect of care on 2/20/20. R1 was interviewed by RN-A on 2/23/20, regarding a different incident at the facility on 2/20/20, and R1 informed RN-A (NA-A) refuses to help, is argumentative and this causes anxiety. R1 was observed sitting up in the wheelchair, just finished breakfast and was interviewed on [DATE], at 9:04 a.m. R1 stated, They know (NA-A) is a problem, I have filed so many grievances here about her and the attitude that she has. I told them in January that (NA-A) has an attitude but she will try to turn it on me and say I am rude or arguing with her especially at night when I am tired and ask her to stop she continues and raises the tone of her voice and is nonstop talking that I am being rude. She will tell me I am independent and she is not going to help me. Yes, (NA-A) has refused to help me and it was over a very long time. She has been reported so many times for behavior, attitude, constantly saying you are independent, do it yourself, her whole attitude was awful She would not help me wipe my behind. I would be in tears, it was humiliating, then (NA-A) would throw up her arms, up in the air and say I am not arguing with you and then walked off and would just leave. She had left me in the shower, she wouldn't spot me when I needed to get into bed. She would say I was supposed to be independent and she was not going to help me. I feel very humiliated and embarrassed and helpless. R2's quarterly MDS dated [DATE], indicated R2 was assessed as cognitively intact, used a walker and required physical assistance of one staff with transferring and limited assistance with locomotion on and off the unit, dressing, toilet use and personal hygiene. R2's CP dated 3/1[DATE]9, indicated R2 had an ADL self-care performance deficit related to [MEDICAL CONDITIONS], and occasional bowel and bladder incontinence. The interventions directed limited assistance with showering, and extensive assist with peri-cares and incontinence care. R2's incident report dated 2/23/20, at 7:00 a.m. included, RN-A asked for breakfast request and how did your night go, to which RN-A documented R2 stated, It was not good. I asked (NA-A) many times throughout the night to provide peri cares and she refused. A follow up report dated 2/28/20, included, (NA-A) was rude and left her trash full, linen all over her room. When she would ask for help to clean herself after she urinated (NA-A) would argue with her. The majority of time the resident does her own cares. Resident currently is being treated for [REDACTED]. One of the questions on the document read, Description of similar incidents that have occurred in the past 6 months: This employee has had resident's express concern related to her attitude. The decision was made today that her attitude does not fit with our values. Employee was terminated on 2/28/20. R2's CP did not address a vulnerability plan for abuse and was not updated to reflect a complaint of neglect of care on 2/23/20. R2 was observed on 3/9/20, at 12:57 p.m. sitting on the side of the bed in the bedroom. When interviewed, R2 stated, I have had many problems with (NA-A) over my use of night time briefs and she would always tell me they did not have the briefs. She would not help me when I needed help to change my briefs, She would be rude and say 'Oh no I don't do that,' she would be rude and walk right out the door without helping me, and she did not come back. I need help to clean myself. She would yell down the hall at night at other residents, I could hear her. R2 further discussed asking NA-A to help with peri care and verified that on 2/20/20, at 5:00 a.m. NA-A was, Rude and confrontational, and refused to help me. NA-A's employee file indicated NA-A was hired 12/18/19, and references were obtained from two friends listed on the application. The application listed a nursing home from 7/3/17 until 12/3/19, but the facility failed to verify the employment. NA-B's employee file indicated NA-B was hired November 2018 as a transfer from another facility which closed. A note in the file dated 2/5/20 indicated NA-B works approximately 104 hours per week. There were no disciplines or evaluations in the employee file. When interviewed on 3/9/20, at 2:30 p.m. the human resource director (HRD) verified employees (NA-A and NA-B) did not have any disciplines, grievances, coaching or evaluations in the employee files. The HRD verified NA-A was terminated 3/4/20, after refusing to sign a performance improvement plan related to handling residents with behaviors, providing care and following resident rights. The HRD verified NA-B was terminated 2/28/20, for gross misconduct and negligence. The HRD verified NA-A and NA-B typically were always scheduled for double shifts. The facility did not have a policy to restrict working double shifts and the HRD was not aware of a facility policy for staff burn out associated with working double shifts. Document review of the facility form titled Daily Staffing Sheet for 2/9/20, indicated NA-A worked on the evening shift for 8 hours and then the night shift for 8 hours ending in the morning of 2/10/20, after 16 hours of consecutive work. Document review of the facility form titled Daily Staffing Sheet for 2/19/20, 2/20/20, 2/21/20, 2/22/20, indicated NA-B worked on the evening shift for 8 hours and then into the night shift for 8 hours, working 16 hours of consecutive work. When interviewed on [DATE], at 9:34 a.m. NA-C stated, I recently have heard other residents have complained about (NA-A) but I am not aware of resident complaints about (NA-B). When interviewed on [DATE], at 9:48 a.m. LPN-A stated, I know that (NA-A) only works double shifts because she is in another state, she is outspoken, and has been known to rub people the wrong way because she is loud, and mannerisms the way she presents herself I know other residents and her do not get along. When interviewed on [DATE], at 10:48 a.m. RN-A stated, I know that (NA-A) had an attitude about (R1). I know there were grievances filed in January but I do not know what happened with that, I thought the two of them were making peace with each other. Furthermore, RN-A verified she did not interview the night staff about what it was like to work with (NA-A). RN-A verified she did not perform audits of NA-A or NA-B job performance. When interviewed on 2/10/20, at 11:20 a.m. NA-D indicated typically worked with NA-B and stated, A couple of times I wondered if the call lights were being answered and or just shut off without doing anything, and then go on break and as if no one had been in the room, the resident woud say, 'that other girl just come in and shut off my call light without helping me'. NA-D verified did report to the director of nursing (DON) concerns about NA-A not answering the call lights and stated, I know I talked to (DON) because I said I did not like to work with (NA-B). When interviewed on 2/10/20, at 11:38 a.m. SW verified that all of the resident vulnerability plans were not updated on the care plans and stated, I have been working on them since January and have not addressed the vulnerability plans on all of the residents yet. Furthermore, SW verified there was no documented individual monitoring following the accusations of abuse for R1, R2, R3 and R4. When interviewed on [DATE], at 11:41 a.m. NA-F recalled a situation with (NA-A) arguing with (R1) over filling of the [MED]gen tank which involved having the nurse come into the room to settle the dispute. When interviewed on [DATE], at 12:15 p.m. the DON verified the facility failed to interview and document staff information/concerns with R1, R2, R3, R4, who expressed specific staff concerns with NA-A and NA-B. Furthermore, the DON verified the staff did not receive resident rights/abuse training following these situations and in particular night shift staff since the incidents were from the night shift. The DON verified there were no audits of the night shift staff pertaining to resident concerns and residents were not followed up with after expressing concerns. The DON verified the facility expectation would be to investigate each case thoroughly according to the facility expected policy for abuse/neglect investigations. The DON further verified that the facility did not discuss specific cases of abuse/neglect with the quality assurance committee and stated, We talk numbers and they are very vague. The DON verified there was no documented physician contact regarding the abuse for R1, R2, R3, and R4 and no documentation to indicate the medical director was informed to ensure quality of life. When interviewed on 3/12/20, at 3:12 p.m. NA-H returned the surveyor call and stated, I reported (NA-A) to the DON as being a disinterested person and that she would spend a lot of time on the phone. She whips through cares or she would not do cares. On the night with (R4) I told (NA-B) she had to get (R4) up to the bathroom with the mechanical device and (NA-B) said she just checked and changed (R4) and did not get her up. I told (NA-B) you have to follow the plan of care. I know (NA-B) argued with (R4) on first rounds, she left her in bed and just changed her. I told (NA-B) when someone wants to get up you have to get them up, This is dignity, how do you want to be treated. I understand the staffing issues, early on I spoke with the staffer that you need to watch your staff if they work too many consecutive doubles they become dangerous. Those two aides (NA-A and NA-B) always worked doubles and were too exhausted to work properly. Document review of the facility policy up dated 6/9/19, titled, Abuse Investigations, indicated the policy was to promptly and thoroughly investigate by facility management. #3. The individual conducting the investigation will, as a minimum: c. Interview the person (s) reporting the incident; d. Interview any witnesses to the incident; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview the resident;s roommate, family member, and visitors. i. Interview other residents to whom the accused employee provides care or services; J. Review all events leading up to the alleged incident. 5. Witness reports will be obtained in writing. Either the staff member will write his/her statement and sign and

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) date it, or the investigator may obtain the staff statement, read it back to the member and have him/her sign and date it. Monitoring and Follow-up; 1. The facility staff and physician will monitor individuals who have been abused at least until their medical condition, mood, and function have stabilized and periodically thereafter. 2. The medical director will advise facility management and staff about systems to ensure that basic medical, functional, and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed appropriately.