STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 55940

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to assess, evaluate and monitor for the reoccurrences of resident-to-resident abuse for 1 of 2 residents (R1) who had a history of [REDACTED]. The immediate jeopardy began on 9/2/20, when the facility failed to prevent R1's recurrent physical aggression towards other residents. The facility had not implemented an effective system of supervision for R1 to remove the risk of continued aggression toward other residents. The administrator and director of nursing (DON) were notified of the IJ on 9/23/20, at 7:27 p.m. The IJ was removed on 9/24/20 at 5:18 p.m., when it could be verified the facility had developed and implemented interventions to minimize risks of resident-to-resident abuse. However, non-compliance remained at the lower scope and severity of D, isolated, no actual harm, with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's Admission Record face sheet printed 9/23/20, included [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated the resident had moderate cognitive impairment, exhibited physical behavior towards others and rejection of care 1-3 days during the assessment period, and utilized a wheelchair (w/c) for mobility. R1's care plan last revised 9/10/20, indicated the resident has had episodes of aggressive behavior and has threatened staff as well as other residents. Resident has made inappropriate sexual comments and needs some guidance to maintain optimal social relationships. Interventions included to remove residents whom may be targeted in times of resident's aggression, and 1:1 (one to one) with validation of feelings when resident is frustrated, agitated. The care plan also indicated the resident has had instances of false accusations of others (someone jumped up and down on him, beat him up, etc.) Family have reported that resident makes false statements about staff persons. Interventions included: If resident making untrue accusation, attempt to identify trigger. Remove trigger if able. Male staff being present have triggered this in the past. Report all accusation to nurse in charge immediately. Increase monitoring and provide support and reassurance as needed if resident exhibiting accusations of others, agitation and seeking out others that he is threatening to harm. Monitor for anxiety, distress and / or fear. Remove others from environment if possible. Redirect and offer calm, quiet environment. Investigate any accusations of abuse or harm from resident. If unable to rule out or explain immediately, follow protocol for filing VA (vulnerable adult) incident report to OHFC (Office of Health Facility Complaints-designated state agency) until full investigation can be completed. R1's Visual/Bedside Kardex Report utilized by the nursing assistants (NAs) included: 1:1 with validation of feelings when resident is frustrated, agitated. If resident is agitated, remove peers from area. Allow resident to wander freely in common areas. Limit number of staff for intervention if possible. Staff to monitor resident while in public areas and if appears to be propelling to room, they will follow and assist with any needs he may have, ensuring when they leave that the call light is within reach and needs met. On 9/22/20, at 12:43 p.m. R1 was observed propelling self out of the dining room and down wing 1 in w/c, holding onto the railing and pulling to assist with movement. No other residents or staff were in the hallway on wing 1 at that time. R1 stopped in front a resident room looking in. There was a female resident in the room lying in bed. R1 remained in the doorway to the room looking in for approximately 2 minutes until a nursing assistant (NA) observed R1 in front of the door and redirected R1 back into the dining room. R1's progress notes dated 9/2/20 included: - 18:32 (6:32 p.m.) Behavior Note Note Text: Resident w/ (with) confrontation seeking, accusing people of stealing money from him. Behaviors began at about 1730 (5:30 p.m.). He was given a PRN (as needed) [MEDICATION NAME] (an antipsychotic medication) at the onset of behavior. Resident was served his evening meal and ate 100% of his meal in the dining room. Behaviors began to escalate after he finished eating. Resident wheeling himself up and down the hallway swinging out and grabbing at anyone who walks by him, staff and residents included. Resident wheeling out to dining room for confrontation. Other residents removed to place of safety and staff to give resident space to de-escalate. Will continue to monitor resident from a distance to ensure safety. - 19:07 (7:07 p.m.) Behavior Note Text: Resident continuing to be confrontation seeking, Kicked another resident (medical record number/R3) who had walked out to dining room. (R3) was in the process of being escorted out of the dining room by NAR (nursing assistant registered). (R3) sustained no injuries and was escorted to safety. Will continue to monitor per nursing measures. R1's physician progress notes [REDACTED]. He unfortunately kicked another resident yesterday. This was a female resident, typically in the past his physical aggression has been directed towards males .Assessment/Plan: Unfortunately had escalation of physical interaction with another resident, kicking them yesterday. Staff note that his behavior seem to be escalating on daily basis and looking at his prn [MEDICATION NAME] use it has been more frequent as the month of August progress and daily here so far in September. Consider dose increase in [MEDICATION NAME] verses addition of another [MEDICAL CONDITION] medications such as [MEDICATION NAME] acid (a mood stabilizer), but I do not think that dose would be appropriate directions to go given his level behaviors at this time. Therefore, decision was made to transition to [MEDICATION NAME] (an antipsychotic medication). [MEDICATION NAME] 5 mg (milligrams) is equivalent to roughly 100 mg of [MEDICATION NAME]. Initial dose will be set plants (sic) pain (sic) 5 mg bid with additional 2.5 mg available daily prn. All this will be less of a total daily equaling dose, hoping the [MEDICATION NAME] will be more effective. May need some further titration. Although the facility contacted the physician to address R1's increase in aggressive behaviors there was no evidence the facility had formally increased supervision of R1 or reported the resident-to-resident altercation between R1 and R3 to the state agency (SA). R1's progress notes dated 9/7/20 - 9/8/20 revealed the following: - 9/7/20 01:32 (1:32 a.m.) Behavior Note Note Text: Resident started grabbing peers walker while it was not in use and attempted to throw it around the dinning (sic) area. Resident is taking dinning (sic) room chairs and attempting to throw them and knock them over. Staff attempted to redirect resident by offering a snack. Resident began to swing at staff, hit staff, and kick staff. Resident had gotten ahold a wooden block from activities and was swinging it at staff. staff (sic) redirected resident to other objects such as socks and removed wooden object from residents reach. Staff attempted to stand back and monitor resident to allow him to calm down. Resident continues to wheel around the dinning (sic) area knocking over chairs and moving tables. Resident entered the nurses station cornering nurse he grabbed the cord for the walkie talkie and yanked it out of nurses ear. he (sic) then grabbed basket of items off of the nurses station counter and then threw it on the floor. Staff continued to attempt to safely redirect resident with conversation about his work before retirement. resident (sic) would respond appropriately and maintain a partial conversation while attempting to hit staff. Staff continues to remain a safe distance from resident to allow him to calm down as well as observe resident so that he does not hurt himself or others. staff (sic) will continue to observe. - 9/7/20 02:14 (2:14 a.m.) Behavior Note Note Text: Resident with [MEDICAL CONDITION]- restlessness and multiple behaviors- was pleasant and talkative with staff at beginning of shift- then one of NAR's called for assistance with him d/t (due to) his behavior- became combative-aggressive towards the NAR and then another NAR that responded to try and assist - when this nurse approached his demeanor was totally different than prior-

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) unsure was (sic) escalated the mood change- the NAR stated she was trying redirect and he became agitated and hasn't stopped being combative and agitated towards all staff - this nurse told all staff to stay down their halls and let him be and I would watch over him- educated that the more people that intervene the worse it becomes- he did take his anger out at all that tried to intervene such as another nurse on in training tried to distract him so this nurse could remove the wooden gadget he took out from the activity shelf and was swinging at everything- she did get hit on hand - he pushed dining room chairs into this nurse shins- swinging out-punching out- running into chair and table- tipping chairs over-banging on chairs- hitting with a rolled up newspaper as in swatting flies -- but hard--- no way to offer the prn [MEDICATION NAME] ([MEDICATION NAME]) to calm him- I tried ice cream- he smashed the container all over the table and and floor -this nurse asked if a new face- younger NAR would try to distract him- at first he was being nice towards the new face then she reported he punched her in the left eye - stated he did it so quick when trying to block his hands-- this nurse will interact 1:1 (one-to-one) the rest of noc shift as to no other staff getting hurt - 2 incident's report filled out so far with his combativeness- has had new med change which is not effective to manage this behaviors this far- --has tried to rip the phone off the wall- throwing and shredding boxes- making threatening comments such as I get ahold of you I will punch your eyes out- call the cops- see where that gets ya--will stay at distance to monitor. - 9/7/20 03:29 (3:29 a.m.) Behavior Note Note Text: Resident started with heavy eyes and wearing himself out from non-stop all noc (night) so far- took majority of the oj (orange juice) in with the prn [MEDICATION NAME]- was cooperative with this nurse and other nurse with transferring him into bed with EZ (mechanical device) stand- allowed incontinent cares and also allowed to face wash face and mattered eyes- 02 (oxygen) supplement on and warm blanket from the warmer for comfort- resident very difficult to manage behaviors once he starts- - 9/7/20 23:55 (11:55 p.m.) Behavior Note Note Text: combative, confrontational, active seeking harm towards staff, disruptive yelling out, unable to redirect r/t (related to) behaviors, confusion. verbal and physical threats w/ agitation. striking out, threats to kill everyone. disruptive to facility staff routine of caring for others as Res (resident) will enter others rooms w/ harmful confrontation seeking. - 9/8/20 00:37 (12:37 a.m.) Behavior Note Note Text: staff heard Res (medical record number (MRN)/R3) yelling out help. Res found physically attacking this Res (MRN/R3) while she was sitting in recliner in MDR (main dining room) watching TV. Res striking her, grabbing on RUE (right upper extremity) twisting it attempting to harm. required staff direct intervention for separation of Res r/t behavior w/ disregard to safety of others, confrontation seeking to injure others. accusative (sic) w/ paranoia of others. Res remains disruptive to facility w/ behaviors, calling out, throwing items around MDR and at staff. unable (sic) to deescalate behaviors r/t seeking harmful confrontational behaviors. kicking at, threatening staff In a facility report to the SA dated 9/8/20, at 8:55 a.m. indicated: (R3) was sitting in dining room watching television. Staff heard her calling out for help. Approached and observed (R1) grabbing her right arm and twisting it with the apparent attempt to injure her. Staff intervened immediately and separated residents. (R3) has no injury following incident. (R1) has not sought out resident further since this incident. In the facility's investigative report submitted to SA dated 9/9/20, at 9:10 a.m. indicated R1's care plan was updated to remove others from area if resident expressing physical, threatening behavior and provide 1:1 or close observation as needed to ensure resident and others' safety. The investigation also addressed R1's medication change from [MEDICATION NAME] to [MEDICATION NAME] on 9/3/20, and the residents increase in physical and threatening behavior after the medication was changed. R1's [MEDICATION NAME] was discontinued and [MEDICATION NAME] was resumed as that was more effective in managing the residents behavior. Staff were educated on removing other residents from area if a resident is a risk to harming others. Although the investigative report indicated staff would provide 1:1 or close observation as needed should R1 express physical, threatening behavior, there were no formal parameters in place on when or how this increase in supervision would occur. R1's progress note dated 9/16/2020, at 21:52 (9:52 p.m.) indicated: Incident Note Note Text: Resident became restless, and aggressive with staff and peers. nurse (sic) found resident in dining room with peer (R2) and was using his shirt to attempt to choke him from behind. staff (sic) intervened and separated residents. scheduled (sic) [MEDICATION NAME] given med was ineffective. PRN [MEDICATION NAME] administered. Resident continues to have aggressive behaviors and wandering the hallways. staff (sic) will continue to observe. An investigative report submitted to the SA on 9/17/20, at 14:06 (2:06 p.m.) included: Staff heard (R2) yelling out in the dining room at approximated 7:17 p.m. and responded immediately. Nurse was the first person to respond and witnessed (R1) in his wheelchair behind (R2) in his wheelchair in the main dining room. (R1) was holding (R2) by the shirt and shaking him yelling at (R2) to shut up. The shirt was tight across (R2's) neck but staff stated (R2) was breathing and yelling out. Nurse and CNA (certified nursing assistant) intervened and (R1) released (R2's) shirt. (R2) was examined no injuries noted. Prior to incident no trigger was able to be identified and resident appeared calm with staff interactions. (R1) [MEDICATION NAME] order resumed to 100 mg TID (three times a day) & (and) 100 mg PRN on 9/8/20. This medication has been successful in reducing his target behaviors of paranoia and aggression. During investigation staff reported having the dose earlier than at HS (hour of sleep/8:00 p.m.) would be more effective in preventing these behaviors. (Physician name) was updated and time for one of the doses was changed from HS to 6:00 pm. IDT (interdisciplinary team) will continue to monitor (R1) for effectiveness of [MEDICATION NAME] and update provider as needed. Though the facility contacted R1's physician for time change of the HS [MEDICATION NAME], no formal plan to increase supervision of R1 to protect other residents was implemented. When interviewed on 9/22/20, at 12:03 p.m. NA-A confirmed R1 could be physically aggressive towards staff and residents. NA-A stated R1 had a med (medication) change not that long ago and it seemed like the aggressive behaviors started to escalate with the med change. NA-A confirmed R1 was now back on his original medication (did not name the med) and he seemed better as had not exhibited any aggressive behavior in the past 4 days that she'd been working. NA-A stated if R1exhibited escalating behaviors or was going after other residents the staff would separate the residents and keep an eye on R1 to assure safety for other residents. NA-A further stated when R1 was in the dining room they usually would remove the other residents if his behavior was escalating as that seemed to work better than trying to remove R1. Staff also had shut the fire doors to the wing entrances until R1 calmed down to prevent him from trying to enter other resident rooms. NA-A confirmed staff try to keep eyes on R1, especially if he started to exhibit aggressive behavior, though confirmed no formal plan for supervision was in place. When interviewed on 9/22/20, at 4:40 p.m. NA-B confirmed having worked the evening of 9/16/20, though did not witness the altercation between R1 and R2. NA-B stated R1 was kind of iffy that night as to whether he needed a PRN [MEDICATION NAME] or not with the behaviors he was exhibiting. NA-B stated R2 and R3 were in the dining room with R1 just prior to the incident. NA-B had left the dining room area and the altercation happened shortly after that. NA-B confirmed licensed practical nurse (LPN)-A was also working that evening and thought she was the one that came upon the incident first between R1 and R2. NA-B stated staff try to keep visual on R1 and if they don't see him around will walkie each other to see who has eyes on him. NA-B confirmed there were no staff present in the dining room when the incident occurred between R1 and R2. When asked if R1 ever targeted any other residents she confirmed R1 had kicked R3 and also goes after R7 at times or depending upon his mood ,could turn on anyone. NA-B confirmed R1's physical behaviors included hitting, kicking, ramming chair into people or throwing things when agitated. NA-B denied any formal documented increased supervision for R1. When interviewed on 9/22/20, at 4:50 p.m. licensed practical nurse (LPN)-A confirmed having worked the evening shift on 9/16/20, and coming upon the altercation between R1 and R2. LPN-A stated not being sure what triggered the event; she was down wing 3 and heard R2 yelling. I turned and I looked and could see that (R1) had ahold of (R2's) shirt from behind and was trying to choke him with it. LPN-A stated she and NA-A separated R1 and R2 then brought R2 back to his room. LPN-A confirmed R1 remained in the dining room as there was no getting him back to his room. LPN-A further confirmed there were no staff or other residents in the dining room at the time of the altercation. LPN-A stated the staff all kind of took turns monitoring R1 after the incident with the walkie talkies and kept an eye on him at all times. LPN-A stated she had never seen R1 become physically aggressive with another resident though had with staff. LPN-A confirmed prior to the incident on 9/16/20 there was not extra supervision for R1. LPN-A stated at this time if staff start to see R1 get agitated they keep a closer eye on him, and further stated the night of 9/16/20, there wasn't the signs like he wanted to leave or stating someone was after him- that night there wasn't any trigger to make them think he needed increased supervision. LPN-A confirmed there was no formal documented increased supervision in place for R1. During an interview on 9/23/20, at 11:03 a.m. with LPN-B and registered nurse (RN) -A, LPN-B confirmed having worked the evening of 9/2/20 when R1 kicked R3. LPN-B confirmed R1 was agitated that day and the staff had moved all the residents out of the dining room. R3 had walked into the dining room independently so one of the NA's went into the dining room to redirect R3 back to her room. LPN-B stated when the NA started walking with R3 back to her room R1 went after R3 and kicked her. LPN-B confirmed she had not witnessed the altercation but was told this by the NA who did. LPN-B stated she would check in with other staff to see how R 1 was doing

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) and what his mood was throughout the shift. If R1 was wandering up and down the halls they try to keep eyes on him and communicate his whereabouts. RN-A stated if it's a busy time such as at mealtime when the NA's are assisting residents with eating, they involve activity staff with keeping an eye on R1 so he wouldn't go into another resident's room. RN-A further stated R1 had never done that but they want to make sure it wouldn't happen. LPN-B stated if R1 was agitated at times they would shut the fire doors from the dining room into the wings to protect the other residents; if R1 was already in a hallway they would keep eyes on him. LPN-B stated sometimes R1's mood could change very quickly-could be smiling and happy one minute and then can get angry the next. When the resident was agitated is best to watch him from a distance as he doesn't want staff's one to one attention and also would strike out at staff when agitated. RN-A and LPN-B confirmed since R1's antipsychotic medication was changed back to [MEDICATION NAME] and with the dosing time changes his mood had been better though was still doing a lot of wandering but not as aggressive. When interviewed on 9/23/20, at 12:44 p.m. case manager registered nurse (RN)-B stated R1 typically targeted aggression towards certain residents, and staff could usually tell when R1 was ramping up. Staff would then get the other residents out of R1's area which was usually the dining room. RN-B confirmed R1 would target R3 and R7, though R1 had never been physically abusive with R7, more verbal. RN-B confirmed R1 kicked R3 one weekend, a couple times, mostly he thinks R3 is his wife. Related to the altercation between R1 and R2 on 9/16/20, RN-B stated, That was an unusual situation, he usually doesn't go after (R2). RN-B confirmed both altercations occurred in the evening and staff were monitoring R1 every 30 minutes to one hour and that should be documented. RN-B further confirmed the increased monitoring was implemented after the first time R1 kicked R3 on 9/2/20. After the incident between R1 and R2, RN-B stated to her knowledge R1's supervision continued at 30 minutes to an hour checks. RN-B and RN-A checked the electronic medical record (EMR) to verify documentation of increased supervision of R1 following the incidents with R3 and R2. RN's were unable to locate evidence of increased monitoring in the EMR. RN-A stated she would also check her office as staff may have been documenting the increase in supervision on paper. RN-A further stated on the evening of 9/16/20, following R1's altercation with R2, the director of nursing (DON) had come into the facility and provided 1:1 supervision of R1 for a period of time. When asked what staff would do to keep residents safe after a physical altercation, RN-B confirmed supervision would be increased. RN-B stated R1's aggressive behaviors typically happened on the evening shift. The evening shift knew if R1's behaviors started to increase to utilize the prn [MEDICATION NAME] and they were good about doing that. RN-A and RN-B were unable to find any evidence of increased monitoring of R1 by staff either on paper or in the EMR. When interviewed on 9/23/20, at 1:39 p.m. the director of nursing (DON) stated at the time of the incident on 9/2/20 when R1 kicked R3, staff were trying to keep R3 safe by getting the resident out of the dining room where R1 was located. DON confirmed the altercation was not reported as a VA as R3 had no injury, though in hindsight should have reported it. DON stated that when R1 is ramping up staff try to get everyone out of the dining room. R3 is strong willed and sometimes doesn't want to leave. If we can see that R1's behavior is escalating sometimes would have a staff member stay in the dining room with him - sometimes it's hard to know when it's coming. DON stated at times the nurse of trained medication aide (TMA) will station the med cart in the dining room to stay in visual sight of R1 while passing medications to keep an eye on him. DON confirmed the resident would not be 1:1'd at that time but would be less then 30 minutes between visual checks. After the incident during the early morning of 9/9/20 between R1 and R3, night staff were re-educated that R3 was not to be going out to the dining room when R1 was up and out there. DON confirmed R3 was in the recliner resting when R1 came upon her. DON further confirmed R1 was exhibiting behaviors that evening and would have expected staff to remove R3 out of the dining room and did retrain them about that as well. When interviewed on 9/23/20, at 3:20 p.m. NA-D confirmed having worked the night shift on 9/7/20 into the morning of 9/8/20. NA-D confirmed R1 had been combative that night and had punched one of the NA's in the eye. NA-D stated R3 was sleeping in the recliner in the dining room. NA-D was doing her rounds and could hear R3 screaming; by the time NA-D got to the dining room the nurse had got in between R1 and R3. NA-D thought R3 was just scared because R1 had grabbed a hold of her and wouldn't let go until the nurse snatched him away. NA-D confirmed knowledge of R3's presence in the dining room and stated, Everyone knew she was out there because she's always there at night. NA-D stated R3 sleeps wherever she wants and lots of times will sleep in the chair by the nurses station, she never stays in her room. NA-D was not sure if the facility was doing any increased monitoring/supervision of R1 as she no longer worked at the facility. When interviewed on 9/23/20, at 3:34 p.m. LPN-C confirmed having worked the night shift on 9/7/20 into the morning of 9/8/20. LPN-C stated R1 was very agitated all day from what he understood; this was pre-[MEDICATION NAME] because they had put him on [MEDICATION NAME]. R1 was attacking the staff which was normal when he got like that. R1 was the only one up at the time; R3 had been up and about and then went back to her room. Then I heard R3 hollering, Help, help, help!. Screaming it rather than just saying it like she usually does. R1 was grabbing on R2's right arm, hunched over in his w/c. I don't' know if he hit her but he was grabbing on her arm threatening her. LPN-C confirmed separating R1 and R3 then another staff went with R3 to her room. At one point R1 went down to R3's room and staff redirected him. R1 laid down about 5:00 a.m. but was back up around 6:00 a.m. when I left for the day. LPN-C stated he had no knowledge that R3 had come back out to the dining room. I didn't even hear her until she started screaming help. I didn't know she was out in the dining room, had I known I would have redirected her back to her room. When R1 is in one of those moods he's attacking everyone so we make sure the other residents are away from him cuz there's no way you're gonna keep him isolated. The night crew all know that if R1 is in this type of agitated mood that the other residents need to be separated from him. LPN-C confirmed R1 had gone after other residents in the past but it had been awhile and that's before he was on any [MEDICAL CONDITION] medications. LPN-C further confirmed R1 and R7 had gotten into it before. LPN-C wasn't sure if R1 was on any increased monitoring/supervision as had been on vacation for the past 2 weeks. When interviewed on 9/23/20, at 5:53 p.m. the DON confirmed the facility had not implemented formal documented monitoring/supervision for R1 related to the incidents of resident-to resident abuse. The facility policy titled, Resident Protection Plan revised October 2019, included: Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. The immediate jeopardy that began on 9/8/20, was removed on 9/24/20 at 5:18 p.m., when the facility developed and implemented interventions to ensure residents at risk for resident-to resident abuse were safe by: Implementing 30 minute checks for R1 with documentation of any behaviors displayed. Assigning one staff each shift to be responsible for R1's 30 minute checks, 1:1 the resident should he display any symptoms that may indicate he could harm himself or other residents, and to remove all residents who may be in danger. Finally, the facility comprehensively assessed R1's cognitive status and risk factors noting symptoms associated with past aggression to include: paranoia; accusatory statements toward staff or other residents; verbal aggression; resistance with cares; moving quickly in the halls or dining room; moving furniture; talking about going home.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident-to-resident abuse was reported to the State Agency (SA) in a timely manner in accordance with established policies and procedures, for 1 of 3 residents (R3) who were reviewed for abuse. Findings include: R3's Admission Record printed 9/23/20, included [DIAGNOSES REDACTED]. R3's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R3 had moderate cognitive impairment and exhibited wandering behavior 4-6 days but less than daily during the assessment period. The MDS further indicated R3 was independent with locomotion on the unit. Review of the care plan last revised 9/15/20, indicated R3 was a vulnerable adult (VA) due to physical and cognitive impairments. Interventions included to report all allegations of abuse/maltreatment toward resident immediately to the state agency (SA). Complete investigation and put interventions in place to protect residents from future instances. Review of R3's Field Crest Care Center Resident Incident Report dated 9/2/20, at 8:00 p.m. indicated the following: This resident was kicked by another resident (medical record number/R1) in the right lower leg. This resident sustained [REDACTED]. Denies pain r/t (related to) incident, stating that it wasn't hard and didn't hurt. Altercation was witnessed by NAR (nursing assistant registered). Will continue to monitor per nursing measures. There was no evidence to indicate the altercation had been reported to the SA. Review of a facility provided allegation report submitted to the SA on 9/8/20 at 8:55 a.m., indicated a resident to resident altercation had occurred. R3 was in the dining room watching television when staff heard the resident calling out for help. When staff went into the dining room they observed R1 grabbing R3's right arm and twisting it with the apparent attempt to injure her. Staff intervened immediately and separated the residents; R3 was not injured. The report further indicated the altercation occurred on 9/8/20 at 00:30 (12:30 a.m.), 8

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FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST HAYFIELD, MN 55940**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) hours and 25 minutes earlier. The facility failed to report the allegation to the SA immediately. When interviewed on 9/23/20, at 1:23 p.m. the social services director (SSD) confirmed the altercation between R1 and R3 on 9/2/20, had not been reported to the SA. SSD was unsure why the director of nursing (DON) chose not to report the incident to the SA. SSD further confirmed the altercation between R1 and R3 on 9/8/20, was reported late to the SA. SSD stated the morning of 9/8/20, having read the progress notes and knew immediately that the incident should have been reported within 2 hours. SSD further stated having talked with the nurse on duty present during the incident (licensed practical nurse (LPN)-C) who indicated had tried to report the incident to the SA after it occurred but had difficulty getting through. SSD confirmed LPN-C had not notified other staff the incident still needed to be reported. SSD stated having educated LPN-C to call SSD if having problems with filing VA reports timely. When interviewed on 9/23/20, at 1:39 p.m. the director of nursing (DON) confirmed the altercation between R1 and R3 on 9/2/20, had not been reported to the SA. DON stated they weren't sure how much contact there was with R1 kicking R3 as there was no injury or redness on R3's right lower leg, though in hindsite the incident should have been reported. The facility policy titled, Resident Protection Program-Investigation, last revised October 2019, included: 1. An incident or suspected incident of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property must be immediately reported to the administrator. The administrator will be notified in person or by phone. 2. An initial report will be completed and submitted to the state agency via Office of Health and Facility Complaints. (Refer to the Reporting a Vulnerable Adult Incident). a. If the allegation involve abuse or result in serious bodily injury the report must be made no later than 2 hours after the allegation is made.