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

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

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 -** Some	**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 interview and document review, the facility failed to ensure allegations of abuse were appropriately reported to the required person(s) and agencies, investigated and adequate protection provided to ensure freedom from abuse for 3 of 6 residents (R9, R10, R11) whose allegations were reviewed. These findings constituted an immediate jeopardy (IJ) situation which had potential to affect 16 of 16 residents who resided on the Rum River Place secured memory unit at the time of the survey as TMA-A continued to work despite allegations of abuse towards residents. The IJ began on 6/27/20, when an employee (trained medication aide (TMA)-A) was witnessed with her hands grasped around R9's wrists while voicing to the resident, You're not going to hit me again. We're not doing this tonight! Following the incident, no formal re-education was completed for TMA-A and no subsequent audits or monitoring of her care was implemented to ensure residents remained free of abuse. On approximately 7/1/20, a second incident was witnessed and reported to the unit manager regarding TMA-A where she had been witnessed yelling and being mean to a different resident in the locked memory care unit. This allegation was not acted upon, reported or investigated and TMA-A continued to work unsupervised with no protection plan(s) being implemented to ensure all residents on the locked unit remained safe and free of abuse by TMA-A. The administrator (via telephone), director of nursing (DON) and registered nurse (RN)-A were notified of the IJ on 7/17/20, at 4:26 p.m. The IJ was removed on 7/18/ 20, at 5:25 p.m. when the facility successfully implemented a removal plan; however, non-compliance remained at a pattern scope with potential for more than minimal harm which is not immediate jeopardy (Level E). Findings include: A submitted initial State agency (SA) report, dated 6/27/20, identified an allegation of physical abuse regarding R9 which read, Conduct intended to produce pain/injury or rough handling. The report identified on 6/27/20, at 7:40 p.m. an incident happened in the hallway of the locked memory care unit which included, (R9) was attempting to walk another resident . staff intervened and (R9) was upset about being distracted and attempted to hit (TMA-A). (TMA-A) grabbed the resident's wrist and stated, 'you need to stay out here.' Another staff reported that (TMA-A) said, 'We are not doing this tonight.' The report identified the supervisor was notified and TMA-A was sent home until further investigation could be completed. A corresponding undated Verification of Investigation (VOI) report identified the facility completed an investigation into the allegation submitted to the SA on 6/27/20. The report outlined, (R9) was attempting to walk another resident and verbalized intent to assist with toileting, staff intervened and (R9) was upset about being distracted and attempted to hit (TMA-A). (TMA-A) grabbed (R9's) wrist and stated, 'you need to stay out here.' Another staff reported that (TMA-A) said, 'we are not doing this tonight. The report identified the supervisor was notified of the incident and TMA-A was sent home pending further investigation. R9 expressed feeling safe at the nursing home; however, when questioned if she was afraid of anyone at the nursing home, R9 was recorded as, . she shrugged her shoulders and said 'I just ignore them' and started chuckling. The administrator, DON, social worker, physician and SA were all notified of the incident, and a series of witness statements were listed which included statements from multiple staff members including nursing assistant (NA)-A, NA-B, and TMA-A. NA-A's recorded interview described TMA-A as being witnessed with a grip on (R9's) wrist and she was pulling her aggressively, and (R9) almost tripped. NA-A instructed TMA-A to be gentle to which TMA-A responded, I am so done, as she threw her hands up in the air. NA-A described R9 immediately following the incident as, She seemed scared. Further, the report concluded with an, Investigation Summary, which outlined TMA-A had intercepted R9's attempt to strike her which . was interpreted as rough behavior on (TMA-A's) part by another staff member who intervened . The DON then re-educated TMA-A on customer service and professional communication. The submitted SA investigation (5-Day Report), dated 7/3/20, was reviewed and identified R9's care plan was reviewed and followed, along with the facility policy which was listed as, . followed, and no changes were made after the incident occurred. The facility's completed investigation was outlined which reflected the VOI detail(s) in large, and an additional form was attached which demonstrated TMA-A had been provided with a verbal disciplinary action along with education on customer service and professional behavior. The form was signed by the DON on 6/29/20, and TMA-A was listed as having verbally acknowledged the form through a telephone call on 6/29/20. The space provided for the administrator to sign the form was left blank and unsigned or dated. There was no evidence in the completed VOI or subsequent SA investigation demonstrating TMA-A had been formally re-educated on the facility's abuse policies and procedures including what constitutes abuse or any education on understanding behavioral symptoms of residents which could increase the risk of abuse and how to respond. A provided resident listing, dated 7/16/20, identified a total of 16 residents resided on the Rum River Unit (locked memory care unit) including R9, R10 and R11. R9's annual Minimum Data Set (MDS), dated [DATE], identified R9 had severe cognitive impairment; however, demonstrated no delusions or physical behavioral symptoms (i.e. hitting, kicking). On 7/17/20, at 9:50 a.m. R9 was interviewed in her room. R9 voiced she was not sure how long she had lived at the nursing home and just replied, No, when asked if she had any concerns with staff treatment or her care. On 7/17/20, at 10:52 a.m. nursing assistant (NA)-A was interviewed and stated she had worked with TMA-A on the evening of 6/27/20, when she stayed late to help put residents to bed. NA-A explained R9 was a resident who frequently wandered into a specific resident' room to use their bathroom and needed to be re-directed; however, at approximately 7:30 p.m. NA-A stated she had come out of a resident room and witnessed TMA-A's hands grasped and squeezing around R9's wrists as R9 seemed to struggle to free herself from TMA-A's grasp by shaking and pulling back. NA-A stated she immediately told TMA-A to let go of R9, however, TMA-A did not and continued to grasp R9's wrists, so NA-A quickly tossed the linens in her hands into a resident room and returned to R9 and TMA-A who remained in the hallway. TMA-A then released R9's wrists and yelled, I'm so done as she walked away from R9. NA-A proceeded to help R9 to use a bathroom on the opposite end of the unit and R9 was upset immediately following the incident, R9 even voiced she thought TMA-A had left bruising on her. NA-A completed R9's cares and then reported the allegation and incident to the working supervisor who subsequently reported it to the DON. NA-A voiced TMA-A was not allowed to complete her shift the night of the incident involving R9 as she was sent home; however, expressed significant concern as TMA-A had subsequently returned to work on the dementia unit on an unsupervised basis. NA-A expressed following TMA-A's return to work, a second incident had happened where TMA-A had potentially abused residents. NA-A stated she knew R11 had expressed concern to a homemaker (HMK)-A that she (R11) had observed TMA-A to place her hands on and shout at another resident (R10) in the memory care unit just a few days after the incident with R9 on 6/27/20. NA-A stated, to her knowledge, HMK-A and R11 did report these concerns to the registered nurse unit manager (RN)-B; however, added she was concerned as, I don't know if they even looked into that much. NA-A stated she had known TMA-A to be very aggressive at times with residents with her tone of voice; however, had never witnessed her be physically abusive with residents until the incident on 6/27/20, adding, I saw what I saw. Further, NA-A reiterated she was concerned TMA-A would continue to potentially abuse residents on the locked memory care unit as TMA-A continued to work, as of that day (7/17/20), on an unsupervised basis for eight hours of the night (shift). R11's quarterly

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 -** Some	(continued... from page 1) MDS, dated [DATE], identified R11 had severe cognitive impairment; however, demonstrated no delusions or hallucinations. When interviewed on 7/17/20, at 11:25 a.m. R11 stated she had lived at the nursing home for approximately four years as she needed help with her diabetes management. R11 stated she had no concerns about the way staff treated her; however, expressed she had recently seen a female staff member (TMA-A) abusing a resident in a wheelchair. R11 described TMA-A's actions as grabbing her and pushing her while holding her arms and wrists up to the surveyor. R11 described TMA-A as loud while she helped people and voiced she, herself, had never had an issue with TMA-A; however, added the other people (residents) they're not talking (due to cognitive impairment). R11 reiterated the incident she had observed between a resident and TMA-A as something she felt was not nice and not right. R11 expressed she told a staff member about the incident; however, was not able to remember who, but added she reported TMA-A to them as someone who was mean and screams at people. On 7/17/20, at 1:47 p.m. HMK-A was interviewed and verified R11 had reported a concern to her approximately two weeks ago which alleged TMA-A had grabbed another resident. HMK-A described R11's reported concern to her as TMA-A was yelling at this other resident and took her arm and pulled her. HMK-A stated she told R11 they needed to go and report the incident to the unit manager and described R11 as upset by it (the incident), as she was talking very fast while reporting it and almost manic and not breathing between words. HMK-A explained R11 was fearful of retaliation by TMA-A and told HMK-A she (didn't) want her (TMA-A) mad at me. HMK-A verified the incident witnessed and reported to her by R11 was reported to the unit manager (RN-B); however, she was unsure of specific follow-up which had been completed as there had already been a different incident reported pertaining to TMA-A around the same time frame. Further, HMK-A stated she had never personally witnessed TMA-A to be physically abusive to a resident; however, had witnessed her to become impatient with residents before and seem a little frustrated while providing direction or cares to them. On 7/17/20, at 2:02 p.m. TMA-A was interviewed and stated her current employment was full time at the nursing home. TMA-A started working at the nursing home in January 2020, and typically worked during the overnight hours. TMA-A described the incident from 6/27/20, which involved R9. TMA-A had stepped in front of R9 to re-direct her which caused R9 to get upset and attempt to hit out at TMA-A. TMA-A verified she then grabbed R9's arm to stop her and said, You're not going to hit me. We're not doing this today. At the same time, another staff member had walked out of a room and observed the interaction while directing TMA-A, Oh my God, you need to be nice. TMA-A stated she didn't feel she had grabbed R9 with a closed hand around her wrists, however, said it was more like she grabbed her arm and pushed it down. TMA-A stated she could not recall anymore specifics from the event; however, added since it had happened she had been spoken to by the DON on things like mannerisms and professionalism. TMA-A added she thought the DON had also discussed with her the various acts, including placing hands on a resident like the incident on 6/27/20 outlined, could constitute abuse and would not be acceptable. TMA-A denied any further incidents with residents on the memory care unit and voiced she continued to work alone on the memory care unit on the overnight shift. TMA-A stated she was not aware of being placed on any formal buddy-systems for cares or monitoring of the care she provided, adding she had just worked last on 7/15/20, and was scheduled to work again in the coming days. When interviewed on 7/17/20, at 2:29 p.m. registered nurse (RN)-D stated they typically work on the overnight shift and verified working full-time with TMA-A adding, She's my TMA. RN-D acknowledged they were aware of an incident involving R9 and TMA-A which had occurred in the past weeks; however, did not witness it or recall specifics. RN-D stated they had not been instructed or directed to do any monitoring or observing of TMA-A's cares or demeanor while at work. RN-D verified TMA-A is left alone for her job most of the time while working as they were often on a different unit adding, Most days she works alone. On 7/17/20, at 2:33 p.m. RN-B and the DON were interviewed and expressed the facility's administrator was off campus on vacation at the time of the survey. The DON described her understanding of the incident involving TMA-A and R9 on 6/27/20, as a situation where R9 was trying to walk another resident in the hallway and TMA-A attempted to intervene which caused R9 to react. TMA-A then placed her hands around her (R9) wrists to prevent her from striking out. NA-A had walked out of a room in the middle of the incident and observed the grabbing of the wrists and so she reported it to the supervisor, TMA-A was sent home, and the incident report was filed to the SA. The DON stated she was unsure of the exact manner or specifics regarding TMA-A's hands and the subsequent grip she had around R9's wrists (i.e. open hand pushing down on the wrists or a closed fist around the wrists) as she did not question it at the time with the staff members; however, voiced such actions could constitute abuse depending on how the resident is grabbed and how aggressive the overall situation was at the moment. The DON explained they interviewed TMA-A regarding the 6/27/20, incident as part of their overall investigation, and TMA-A felt her actions were not abusive. The DON verbalized she told TMA-A her actions could be perceived as abusive and then had a lengthy conversation with TMA-A on professionalism and customer service as a result of the incident on 6/27/20; however, she did not complete or assign her any formal Relias (computerized healthcare training) courses on abuse, vulnerable adult (VA) or dementia-related policies and procedures. The DON verified TMA-A returned to work on 7/1/20, on an unsupervised basis with no formal audits or monitoring of her care being completed or implemented. RN-B recalled R9 had voiced being scared immediately following the incident on 6/27/20. As part of the investigation, RN-B had attempted to interview other residents on the locked memory care unit she felt would be able to cognitively respond which included R11. RN-B stated R11 did not initially report any concerns about TMA-A; however, within a couple days following their discussion, R11 and HMK-A approached her and reported a second allegation of abuse involving TMA-A and a different resident (R10). RN-B stated she felt the initial discussion with R11, as part of the 6/27/20, incident follow-up, had planted a seed in R11's mind which caused her to report the second allegation as R11 had a history of [REDACTED]. An undated, untitled copy of the taken notes was provided. The notes identified TMA-A's name at the top along with various one-line sentences which included: Always pulling (R10) - come here, Just happened a couple of days ago, She's mean, She's nice to me, Yells-too aggressive. Threatens them, and, (R11) pulled (HMK-A's) arm to demo - quite agressively (sic). The interview continued and RN-B stated she would not consider R10 or R11 to be a credible historian (despite having selected R11 to interview as part of the 6/27/20 incident), but added things R11 had reported in the past seemed to always (have) a basis of truth. When questioned how the second allegation was handled and investigated, RN-B stated she did not immediately report the allegation to the administrator or DON as she did not feel it was credible as it's coming from (R11), that's why. RN-B stated she placed no formal monitoring of TMA-A's cares, nor did she complete any re-education with TMA-A as part of the second allegation and verified, as of 7/17/20, TMA-A remained working unsupervised on the night shift with the resident population on the Rum River Unit. The DON stated this was the first time I am hearing of the second event (allegation) and voiced, had she and the administrator been told of it, she would have reported it as an allegation of abuse and investigated it as such in accordance with their abuse prevention policy. RN-B and the DON expressed that, to their knowledge, the facility's administrator had no knowledge of the second allegation being reported to RN-B. A provided Vulnerable Adult Report / Tracking Log, dated 10/17/19 to 7/16/20, identified all facility reported incidents (FRI) to the State agency. The listing lacked evidence R11's allegation of abuse pertaining to TMA-A was reported to the State agency. TMA-A's undated training transcript identified TMA-A was hired at the nursing home on 2/20/20. A course named, Abuse & Neglect Self-Paced, was listed as being completed on 2/20/20. A second course with the same name was listed which was not completed; however, listed a 'Due Date' of 7/31/20. There was no evidence on TMA-A's transcript or any other provided documentation demonstrating TMA-A had been formally re-educated on the definitions of abuse, nor subsequent strategies to handle behaviors from cognitively impaired residents after the allegation of abuse was reported and investigated, ending on 7/3/20. Further, there were several classes listed, including [MEDICAL CONDITION] and Related Disorders: Behavior Management, which had listed 'due dates' prior to 7/1/20; however, the classes were not completed and no completion date was identified. In addition, there was no evidence provided during the survey demonstrating TMA-A had been placed on any formal monitoring upon her return to work to ensure she completed therapeutic approaches for the residents and did not engage in potentially abusive behavior(s) towards them despite multiple allegations of abuse being reported pertaining to her. A provided Schedule dated 7/1/20 to 7/31/20, identified TMA-A had worked from 6:45 p.m. to 7:15 a.m. on the following days: 7/1/20, 7/6/20, 7/7/20, 7/10/20, 7/11/20, 7/12/20, and 7/15/20. Further, the schedule outlined TMA-A continued to be scheduled for the same shift hours on 7/20/20, 7/21/20, 7/24/20 and 7/29/20. The facility's Vulnerable Adult - MN policy, revised 10/31/19, identified all staff members must report suspected or alleged abuse immediately and added, The administrator is responsible for the implementation of the policy. The policy outlined residents have a right to be free from verbal and physical abuse and all residents of the facility were considered vulnerable adults. The policy directed, Each employee is responsible to report suspected/alleged violations of mistreatment . immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury ., and, The Administrator will be notified immediately. The policy listed a series of sections which were meant to address and prevent allegations of abuse. A section labeled, Prevention/Protection, identified all staff were trained to

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F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) understand the facility' abuse prohibition plan along with identify inappropriate behaviors (i.e. rough handling, derogatory language) and added, If a staff member at any time displays suspect or inappropriate behavior, the supervisor must intervene and take appropriate action. A section labeled, Resident Protection During Investigation, was listed which directed to provide immediate safety of the resident(s) upon identification by completing actions which included, but were not limited to, removing the resident from the alleged perpetrator (AP) care or suspending them. Further, the policy directed all reports of suspected or alleged abuse would be . promptly and thoroughly investigated, which included collecting data around the incident, a physical examination of the resident(s) for signs of abuse and interviews with other residents and staff members. The policy directed to document the results of the investigation and log the incident on a facility Event Summary. The IJ which began on 6/27/20, was removed on 7/18/20, at 5:25 p.m. when the facility successfully implemented a removal plan which included removing the AP from resident care, reporting and beginning the investigation of R11's allegation in accordance with their facility's policy, and educating staff members on the reporting process to ensure all allegations made by residents were reported to the administrator and SA. On 7/18/20, from 4:14 p.m. to 5:13 p.m. interview(s) were completed with direct care and management staff to ensure these items had been successfully implemented.
F 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 an allegation of potential physical abuse was reported to the administrator and State agency (SA) within two hours, as required, for 1 of 6 residents (R11) whose allegations were reviewed. Findings include: R11's quarterly MDS, dated [DATE], identified R11 had severe cognitive impairment; however, demonstrated no delusions or hallucinations. When interviewed on 7/17/20, at 11:25 a.m. R11 stated she had lived at the nursing home for approximately four years as she needed help with her diabetes management. R11 stated she had no concerns about the way staff treated her; however, expressed she had recently seen a female staff member (TMA-A) abusing a resident in a wheelchair. R11 described TMA-A's actions as grabbing her and pushing her while holding her arms and wrists up to the surveyor. R11 described TMA-A as loud while she helped people and voiced she, herself, had never had an issue with TMA-A; however, added the other people (residents) they're not talking (due to cognitive impairment). R11 reiterated the incident she had observed between a resident and TMA-A as something she felt was not nice and not right. R11 expressed she told a staff member about the incident; however, was not able to remember who, but added she reported TMA-A to them as someone who was mean and screams at people. On 7/17/20, at 1:47 p.m. HMK-A was interviewed and verified R11 had reported a concern to her approximately two weeks ago which alleged TMA-A had grabbed another resident. HMK-A described R11's reported concern to her as TMA-A was yelling at this other resident and took her arm and pulled her. HMK-A stated she told R11 they needed to go and report the incident to the unit manager and described R11 as upset by it (the incident), as she was talking very fast while reporting it and almost manic and not breathing between words. HMK-A explained R11 was fearful of retaliation by TMA-A and told HMK-A she (didn't) want her (TMA-A) mad at me. HMK-A verified the incident witnessed and reported to her by R11 was reported to the unit manager (RN-B); however, she was unsure of specific follow-up which had been completed as there had already been a different incident reported pertaining to TMA-A around the same time frame. A provided Vulnerable Adult Report / Tracking Log, dated 10/17/19 to 7/16/20, identified all facility reported incidents (FRI) to the State agency. The listing lacked evidence R11's allegation of abuse pertaining to TMA-A she voiced to RN-B had been reported. Further, R11's medical record lacked any evidence the allegation had been reported to the administrator and/or SA since being voiced to HMK-A and RN-B On 7/17/20, at 2:33 p.m. RN-B and the director of nursing (DON) were interviewed and expressed the facility' administrator was off campus on vacation at the time of the survey. RN-B explained she had interviewed R11 as part of a different allegation; however, within a couple days following their discussion, R11 and HMK-A approached her and reported a second allegation of abuse involving the same staff member and a different resident. RN-B stated she could not recall specifics of the second allegation HMK-A and R11 had shared with her; however, recalled she had taken notes about it on a personal note-pad when the allegation was reported to her. An undated, untitled copy of the taken notes was provided. The notes identified TMA-A's name at the top along with various one-line sentences which included: Always pulling (R10) - come here, Just happened a couple of days ago, She's mean, She's nice to me, Yells-too aggressive. Threatens them, and, (R11) pulled (HMK-A's) arm to demo - quite agressively (sic). RN-B stated she would not consider R11 to be a credible historian, but added things R11 had reported in the past seemed to always (have) a basis of truth. When questioned how the second allegation was handled and investigated, RN-B stated she did not immediately report the allegation to the administrator or DON as she didn't feel it was credible as it's coming from (R11), that's why. The DON stated this was the first time I am hearing of the second event (allegation) and voiced, had she and the administrator been told of it, she would have reported it as an allegation of abuse in accordance with their abuse prevention policy. RN-B and the DON expressed that, to their knowledge, the facility' administrator had no knowledge of the second allegation being reported to RN-B. The facility' Vulnerable Adult - MN policy, revised 10/31/19, identified all staff members must report suspected or alleged abuse immediately and added, The administrator is responsible for the implementation of the policy. The policy outlined residents have a right to be free from verbal and physical abuse and all residents of the facility were considered vulnerable adults. The policy directed, Each employee is responsible to report suspected/alleged violations of mistreatment . immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury ., and, The Administrator will be notified immediately.
F 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 interview and document review, the facility failed to ensure allegation(s) of potential physical abuse and/or neglect were thoroughly investigated and addressed for 2 of 6 residents (R11, R6) whose allegations were reviewed. This had potential to affect 16 of 16 residents identified to reside on the Rum River Unit (locked memory care unit). Findings include: A provided resident listing, dated 7/16/20, identified a total of 16 residents resided on the Rum River Unit (locked memory care unit) including R11. R11's quarterly MDS, dated [DATE], identified R11 had severe cognitive impairment; however, demonstrated no delusions or hallucinations. When interviewed on 7/17/20, at 11:25 a.m. R11 stated she had lived at the nursing home for approximately four years as she needed help with her diabetes management. R11 expressed she had recently seen a female staff member (TMA-A) abusing a resident in a wheelchair by grabbing her and pushing her. R11 described TMA-A as loud while she helped people and voiced she, herself, had never had an issue with TMA-A; however, added the other people (residents) they're not talking (due to cognitive impairment). R11 reiterated the incident she had observed between a resident and TMA-A as something she felt was not nice and not right. R11 expressed she told a staff member about the incident; however, was not able to remember who, but added she reported TMA-A to them as someone who was mean and screams at people. On 7/17/20, at 1:47 p.m. HMK-A was interviewed and verified R11 had reported a concern to her approximately two weeks ago which alleged TMA-A had grabbed another resident. HMK-A described R11's reported concern to her as TMA-A was yelling at this other resident and took her arm and pulled her. HMK-A stated she told R11 they needed to go and report the incident to the unit manager and described R11 as upset by it (the incident), as she was talking very fast while reporting it and almost manic and not breathing between words. HMK-A explained R11 was fearful of retaliation by TMA-A and told HMK-A she (didn't) want her (TMA-A) mad at me. HMK-A verified the incident witnessed and reported to her by R11 was reported to the unit manager (RN-B); however, she was unsure of specific follow-up which had been completed as there had already been a different incident reported pertaining to TMA-A around the same time frame. Further, HMK-A stated she had never personally witnessed TMA-A to be physically abusive to a resident; however, had witnessed her become impatient with residents before and seem a little frustrated while providing direction or cares to them. On 7/17/20, at 2:33 p.m. RN-B and the director of nursing (DON) were interviewed and expressed the facility' administrator was off campus on vacation at the time of the survey. RN-B explained she had interviewed R11 as part of a different allegation; however, within a couple days following their discussion, R11 and HMK-A approached her and reported a second allegation of abuse involving the same staff member and a different resident. RN-B stated she could not recall specifics of the second allegation HMK-A and R11 had shared with her; however, recalled she had taken notes about it on a personal note-pad when the allegation was reported to her. An undated, untitled copy of the taken notes was provided. The notes identified TMA-A's name at the top along with various one-line sentences which included: Always pulling (R10) - come here, Just happened a

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) couple of days ago, She's mean, She's nice to me, Yells-too aggressive. Threatens them, and, (R11) pulled (HMK-A's) arm to demo - quite agressively (sic). RN-B stated she would not consider R11 to be a credible historian, but added things R11 had reported in the past seemed to always (have) a basis of truth. When questioned how the second allegation was handled and investigated, RN-B stated she did not immediately report the allegation to the administrator or DON as she didn't feel it was credible. The DON stated this was the first time I am hearing of the second event (allegation) and voiced, had she and the administrator been told of it, she would have investigated it as an allegation of abuse in accordance with their abuse prevention policy. RN-B and the DON expressed that, to their knowledge, the facility' administrator had no knowledge of the second allegation being reported to RN-B. A provided Vulnerable Adult Report / Tracking Log, dated 10/17/19 to 7/16/20, identified all facility reported incidents (FRI) to the State agency. The listing lacked evidence R11's allegation of abuse pertaining to TMA-A she voiced to RN-B had been reported or investigated. Further, no documented evidence was provided during the survey demonstrating it had been investigated. A completed Nursing Home Incident Reporting - Incident Report Summary , printed 7/16/20, identified the facility had submitted a report to the State agency (SA) on 11/14/19, involving R6. The report outlined an allegation of, Emotional or Mental Abuse, and described an incident where it had been identified a nursing assistant (NA) was potentially transferring R6 inappropriately and not in accordance with her care plan. The NA was re-educated, however, it was alleged the NA went back into R6's room at a later date and voiced, Thanks a lot. I might be losing my job because of you. This caused R6 to become upset and cry. A corresponding undated Verification of Investigation (VOI) form identified the 11/14/19 incident involving the NA and R6. The report identified R6 was interviewed and expressed concern for possibly costing (the NA) her job because she had told the (night) supervisor that (the NA) always transferred her in the 2 pt (point) lift by herself. The report identified the administrator and SA were notified of the allegation. A section labeled, Witnesses ., was provided which included interviews from another staff member and the NA involved. A section labeled, Investigation Summary, identified the completed investigation timeline for the allegation along with a plan which included reviewing the StandUp Lift policy with the NA, providing immediate re-education to the NA and reviewing R6's care plan. However, the report and subsequent summary lacked any evidence other resident interviews were completed to help determine potential other allegations of neglect aside from R6; nor did it list any procedures or steps taken demonstrating the NA identified would be monitored or audited to ensure they were implementing care plans correctly to prevent harm or injury to residents. A completed SA investigation (5-Day), dated 11/18/19, identified the investigation was submitted to the SA which outlined the facility' completed investigation along with the identical plan which was listed on the VOI Form. This completed investigation lacked any evidence other resident interviews were completed to help determine potential other allegations of neglect aside from R6; nor did it list any procedures or steps taken demonstrating the NA identified would be monitored or audited to ensure they were implementing care plans correctly to prevent harm or injury to residents. R6's quarterly Minimum Data Set (MDS), dated [DATE], identified R6 had intact cognition and required extensive assistance for transfers. When interviewed on 7/16/20, at 3:07 p.m. R6 recalled the incident from 11/14/19, and denied being upset or fearful of injury while being cared for at the nursing home. R6 stated since the incident, staff had consistently been using two people to transfer her. On 7/17/20, at 10:39 a.m. the director of nursing (DON) was interviewed regarding R6's allegation on 11/14/19. The DON acknowledged the lack of evidence in the investigation summary, and corresponding VOI Form, demonstrating if other residents had been interviewed; or if the NA was placed under any formal audits or monitoring upon the investigation completion to ensure care plans were being followed. The DON voiced she would speak to the unit manager and follow-up. A subsequent interview was held with the DON on 7/17/20, at 12:35 p.m. and she voiced investigation(s) typically included other resident interviews to help determine the scope of the allegation and see if additional allegations are identified. The DON expressed these interviews are done using an audit tool, and provided some completed Customer Service Audits for a total of three other residents which were used as part of their investigation in to R6's allegation. However, all of these provided audits were dated 11/22/19 (four days after the investigation was completed and submitted to the SA). The DON stated she was not aware why they were done after the investigation was completed and the NA identified had already returned to work. Further, the DON verified R6 was to have two people present for transfers per her care plan which was in-effect at the time of the incident on 11/14/19. The NA was re-educated; however, there was no documented evidence she could find demonstrating any subsequent monitoring or audits had been completed of the NA's care since to ensure care plans were being followed. The facility' Vulnerable Adult - MN policy, revised 10/31/19, identified all staff members must report suspected or alleged abuse immediately and added, The administrator is responsible for the implementation of the policy. The policy directed all reports of suspected or alleged abuse would be . promptly and thoroughly investigated, which included collecting data around the incident, a physical examination of the resident(s) for signs of abuse and interviews with other residents and staff members. The policy directed, Document the results of the investigation, and log the incident on a facility Event Summary.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure triggered Care Area Assessments (CAAs) on a significant change in status Minimum Data Set (MDS) were completed to ensure a comprehensive resident assessment for 1 of 2 residents (R1) reviewed for dementia care and services. Findings include: The Centers for Medicare & Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2018, identified the RAI helps nursing home staff gather information on each resident to help ensure care plans are developed and revised. The manual outlined, under Chapter 4: Care Area Assessment (CAA) Process and Care Planning, the RAI consisted of three components which includes the MDS, the CAAs, and the RAI Utilization Guidelines. The manual identified CAAs were required to be completed for OBRA comprehensive assessments (i.e. admission, annual, significant change in status, or significant correction of a prior comprehensive). R1's significant change in status MDS, dated [DATE], identified R1 had anxiety disorder and depression along with both short and long-term memory impairment. The MDS identified R1 consumed daily anti-anxiety and anti-depressant medications, and demonstrated other behavioral symptoms not directed at others (i.e. hitting or scratching self, public sexual acts, disruptive sounds) 1 to 3 times during the look-back period. Further, under Section V of the MDS, the triggered CAA(s) to be completed were identified with included, 02. Cognitive Loss/Dementia, and, 09. Behavioral Symptoms. Both of these triggered CAA(s) had dictation present which read, See CAA summary. R1's medical record was reviewed and lacked evidence the triggered CAA(s) for R1's cognition and behavioral symptoms had been completed. Further, R1's CAAs Summary listing, printed 7/17/20, identified a red colored ! next to each of the CAA(s) which had triggered for the assessment along with a corresponding green colored checkmark under the column titled, Completed. However, despite both the cognition and behavioral symptoms CAA(s) being identified as triggered; there was no green colored checkmark next to them identifying them as completed. When interviewed on 7/20/20, at 10:28 a.m. registered nurse (RN)-C verified she was the RN who completed and signed R1's MDS dated [DATE]. RN-C stated she had reviewed R1's medical record and was unable to find evidence the triggered CAA(s) had been completed. RN-C explained the facility' social services department was responsible to complete those assigned CAAs, and added she had once in awhile noticed they were not getting done. RN-C stated she sends e-mails to persons when they need to be completed, however, does not typically follow-back to ensure they get done. RN-C expressed the facility had not reviewed their processes or done any education to ensure CAAs are completed before the MDS' are submitted since R1's MDS was completed, and added it was important to ensure CAAs are being done as they're part of the whole assessment. A facility' policy on CAA(s) completion was requested; however, none was received.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure care was appropriately coordinated with an outside hematology clinic to reduce the risk of delayed treatment for 1 of 1 residents (R5) reviewed with cognitive impairment and who was sent to a medical appointment unsupervised causing confusion on the reason(s) and course of treatment to be provided. Findings include: A Common Entry Point Intake Form, dated [DATE], identified a concern received by the State

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

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

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) agency (SA) regarding R5. The report outlined R5 had been brought to an off campus medical appointment with no supervision and was unable to explain why he was there to the staff or physician even asking, . how much the vet bill would cost him. R5 had a listed guardian who had expressed to facility' staff he was unable to attend the appointment, so he was waiting to hear if it had been re-scheduled. The report outlined, Due to not having any decision maker available and with him, however, other labs weren't a possibility as (R5) was unable to give consent. R5's admission Minimum Data Set (MDS), dated [DATE], identified R5 had severe cognitive impairment, several medical [DIAGNOSES REDACTED]. R5's Referral Form, dated [DATE], identified R5 had an appointment at 3:00 p.m. that day with a physician off campus at the clinic. A section labeled, Nurse Notes/Reason For Referral, was provided which did not list any reasons for the visit to the physician or notes to be addressed; however, merely listed the nursing home' health unit coordinator (HUC) and registered nurse unit manager (RN)-B's name(s) and a telephone number. The physician signed the note on [DATE] and provided dictation which read, Labs, and, T Bone Marrow Biopsy. R5 was diagnosed with [REDACTED]. R5's corresponding Fairview Geriatric Services note, dated [DATE], identified R5 had been seen for an episodic care visit with pancytopenia listed as the main concern. The note outlined R5, came to follow up with labs that were done on (R5) today. Spoke with the nurse manager to find out what and why labs. (R5) saw (physician) and was at the appointment alone. Not clear why he was there, (R5) did not know and family did not go with. Has known Pancytopenia and so labs done per orders. Nursing already sent them on to the oncologist office or at least spoke with them about the results and so that is where part of the information came from of (R5) being there alone. The note identified R5 as up in a wheelchair and sitting out in the commons area adding, Will respond to simple questions but with his memory loss, staff anticipate much of his needs. The note listed several orders for R5 which included diuretic medication, laboratory monitoring and reeducation of antipsychotic medication dosing. R5's progress note(s) identified the following recorded entries: On [DATE], R5 admitted to the nursing home. R5 was recorded as not knowing the place or time upon admission. On [DATE], a SLUMs test (cognition test) was administered to R5. He scored ,[DATE] which the note outlined, . this indicates dementia. On [DATE], the laboratory called and reported a critical lab value for R5's platelets and hemoglobin. The physician was notified of these. There were no recorded progress notes from the appointment R5 had with the hematology clinic on [DATE]; and R5 expired on [DATE]. R5's medical record was reviewed and lacked evidence the facility had sent or provided the outside hematology clinic with adequate information or guidance to facilitate care and prevent delays in treatment pertaining to R5's appointment on [DATE]; despite R5 having known cognitive impairment. Further, there was no evidence in the record demonstrating R5's family had been contact and agreed to meet R5 at the appointment to help facilitate communication and treatment with the clinic on the facility's behalf. During interview on [DATE], at 11:22 a.m. nursing assistant (NA)-A stated she recalled R5 residing on the Rum River Unit (locked memory care unit) and described him as forgetful, but easily re-directable. NA-A explained when a resident on the unit has an appointment, the staff bring the resident and a prepared envelope down to the van driver and send them. NA-A stated there typically was not a staff member or family present when they bring the resident down to the van adding, I don't believe so. NA-A expressed she was not sure why residents from the unit were sent to appointments unsupervised and added, That's a good question. Further, NA-A stated HUC-A makes appointments for the residents on the Rum River Unit. When interviewed on [DATE], at 11:31 a.m. licensed practical nurse (LPN)-A explained the process for getting residents on the Rum River Unit to their appointments. LPN-A stated sometimes the family will take them, otherwise they go to off campus appointments using a HandiVan service which the HUC will arrange. LPN-A verified staff members do not routinely attend appointments with cognitively impaired residents and stated someone from the nursing home should be contacting family prior to the appointment to ensure someone is going to be there; however, LPN-A acknowledged she (didn't) know if that actually happens. LPN-A voiced she could vaguely remember an episode in the past where a resident had been sent to an appointment and did not know why they were there when they arrived. LPN-A stated she could not recall any revisions or re-education being completed since that incident; however, expressed it was important to ensure someone was with residents at their appointments to advocate for them and ensure accurate reporting is provided to the physicians. On [DATE], at 11:45 a.m. HUC-A was interviewed and verified she made the appointments for the residents residing on the Rum River Unit. HUC-A explained depending on (a resident's) cognitivity they will call family and set-up appointments with them to ensure someone meets them at the site. HUC-A voiced she did not make the decision on who did or did not need to be accompanied to appointments, as that was the unit manager' responsibility. HUC-A stated she typically makes a note on the resident's appointment card regarding if family is meeting someone or not, however, these are not saved or placed in the medical record. Further, HUC-A stated there had not been any revisions or re-education completed with her since R5 resided on the unit adding she was unaware of an incident where R5 had been sent to a medical appointment unsupervised. HUC-A voiced someone should be present so they are supervised. When interviewed on [DATE], at 12:09 p.m. the HandiVan driver (HVD) stated he picks residents up from the nursing home and typically is given an envelope which he provides to the reception desk at the clinic or hospital. He expressed his service was basically a desk to desk service, and someone from the clinic takes over after he checks them in. HVD voiced family, at times, will meet residents from the nursing home at the clinic; however, it was only maybe ,[DATE] (percent) of the time. HVD stated he recalled a hair memory of the incident with R5 and, from what he could recall, thought he dropped him off at the clinic on [DATE], and R5's son or responsible party was not there so he brought him inside, but did not remain with him. Further, HVD stated since the incident with R5, he had never been contacted by the nursing home to discuss the situation or revise any procedures to ensure residents are met by family or kept safe when left unsupervised at the clinic. On [DATE], at 1:25 p.m. registered nurse unit manager (RN)-B was interviewed. RN-B explained family was always able to attend appointments with residents; however, added a lot of the times they do go alone. RN-B voiced the HandiVan driver(s) typically waited for the residents at the clinic to her understanding, and added once they're checked in to the clinic appointments, the resident' safety and care planning becomes the clinic's responsibility and not the nursing homes. RN-B stated there were some residents on the locked memory care unit she would hesitate to send alone to appointments, and voiced while the HUC and her do speak about residents and appointments, there was no formal system to decide who needs supervision and who doesn't for appointments. RN-B added, It's not our policy to make sure somebody's with them. RN-B then reviewed R5's incident from [DATE]. RN-B explained R5 had dementia and could self-propel in his wheelchair. RN-B stated R5 was a resident who probably should have had family or a staff member present with him at off campus appointments as he would likely not give the physician accurate information on his condition(s). RN-B recalled R5's [DATE] appointment and stated the clinic had contacted her via telephone when he arrived and she remembered them being upset and questioning why R5 was at the clinic. RN-B stated clinic's calling and not having adequate information or having situations where the resident is unable to provide the necessary input for the physician had happened before; however, RN-B felt it was very rarely. When questioned on her follow-up actions to ensure a similar situation like R5's incident on [DATE] did not reoccur, RN-B stated she did probably nothing; however, in hindsight, should have brought the clinic' concerns to someone's attention so they could review their system for sending people to appointments. On [DATE], at 2:26 p.m. the director of nursing (DON) and RN-B were interviewed. The DON voiced the nursing home's responsibility was to setup the appointment and arrange transportation and she cannot verify if anyone from the nursing home contacts family to ensure they will be attending with the resident or not. DON added, I assume they would, and she felt that was occurring. The DON stated she felt the incident with R5 on [DATE] happened due to miscommunication between the physician office and R5's family as the nursing home did our part and arranged the transportation for R5. RN-B and the DON verified they had not reviewed their systems or procedures for sending residents to appointments and ensuring care is coordinated and needed information relayed to the providers. The DON voiced she didn't know this was a thing and had we known she would have acted on it and maybe put something in place. A facility policy on coordination of care with outside providers was not provided.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **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 ensure precautions and appropriate supervision was provided to reduce the risk of accidents or injuries for 1 of 1 residents (R5) reviewed who had severe cognitive impairment and was sent to a medical appointment off campus unsupervised. Findings include: A Common Entry Point Intake Form, dated [DATE], identified a concern received by the State agency (SA) regarding R5. The report outlined R5 had been brought to an off campus medical appointment with no supervision and was unable to explain why he was there to the staff or physician even

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) asking, . how much the vet bill would cost him. R5 had a listed guardian who had expressed to facility' staff he was unable to attend the appointment, so he was waiting to hear if it had been re-scheduled. The report outlined concern as sending R5 to the appointment with nobody present could be unsafe. R5's admission Minimum Data Set (MDS), dated [DATE], identified R5 had severe cognitive impairment and required extensive assistance with transfers. Further, the MDS identified R5 had sustained a fall with a fracture within the past six months. R5's undated 48 Hour Initial Plan of Care identified R5 was orientated to self and experienced hallucinations with handwritten dictation present reading, Thinks something is there, Has conversations no one there (sic). Further, the care plan identified R5 had a history of [REDACTED]. R5's Referral Form, dated [DATE], identified R5 had an appointment at 3:00 p.m. that day with a physician off campus at the clinic. A section labeled, Nurse Notes/Reason For Referral, was provided which did not list any reasons for the visit to the physician or notes to be addressed; however, merely listed the nursing home' health unit coordinator (HUC) and registered nurse unit manager (RN)-B's name(s) and a telephone number. The physician signed the note on [DATE] and provided dictation which read, Labs, and, T Bone Marrow Biopsy. R5 was diagnosed with [REDACTED]. There was no recorded directions, including level of assistance and any precautions for R5, to ensure he remained safe while off campus at the appointment. R5's corresponding Fairview Geriatric Services note, dated [DATE], identified R5 had been seen for an episodic care visit with pancytopenia listed as the main concern. The note outlined R5, came to follow up with labs that were done on (R5) today. Spoke with the nurse manager to find out what and why labs. (R5) saw (physician) and was at the appointment alone. Not clear why he was there, (R5) did not know and family did not go with. The note identified R5 as up in a wheelchair and sitting out in the commons area adding, Will respond to simple questions but with his memory loss, staff anticipate much of his needs. The note listed several orders for R5 which included diuretic medication, laboratory monitoring and reeducation of antipsychotic medication dosing. R5's progress note(s) identified the following recorded entries: On [DATE], R5 admitted to the nursing home. R5 was recorded as not knowing the place or time upon admission. On [DATE], a SLUMs test (cognition test) was administered to R5. He scored ,[DATE] which the note outlined, . this indicates dementia. On [DATE], the laboratory called and reported a critical lab value for R5's platelets and hemoglobin. The physician was notified of these. There were no recorded progress notes from the appointment R5 had with the hematology clinic on [DATE]; and R5 expired on [DATE]. R5's medical record was reviewed and lacked evidence the facility had arranged family or staff to accompany R5 to his medical appointment on [DATE], despite being identified with severe cognitive impairment and a history of wandering and falls. Further, the record lacked evidence the facility had communicated to the clinic staff on needed levels of assistance or any needed safety precautions to ensure R5 was kept safe and free of accidents if he needed to be transferred, use the restroom, or attempted to leave the clinic unsupervised. When interviewed on [DATE], at 11:22 a.m. nursing assistant (NA)-A stated she recalled R5 residing on the Rum River Unit (locked memory care unit) and described him as forgetful, but easily re-directable. NA-A explained when a resident on the unit has an appointment, the staff bring the resident and a prepared envelope down to the van driver and send them. NA-A stated there typically was not a staff member or family present when they bring the resident down to the van adding, I don't believe so. NA-A expressed she was not sure why residents from the unit were sent to appointments unsupervised and added, That's a good question. Further, NA-A stated R5 used to often verbalize he wanted to go home and she could see R5 becoming confused at the appointment and wondering why he isn't home and wanting to go home then trying to leave the clinic. On [DATE], at 11:45 a.m. HUC-A was interviewed and verified she made the appointments for the residents residing on the Rum River Unit. HUC-A explained depending on a residents cognition they will call family and set-up appointments with them to ensure someone meets them at the site. HUC-A voiced she did not make the decision on who did or did not need to be accompanied to appointments, as that was the unit manager' responsibility. HUC-A stated she typically makes a note on the resident's appointment card regarding if family is meeting someone or not, however, these are not saved or placed in the medical record. Further, HUC-A stated there had not been any revisions or re-education completed with her since R5 resided on the unit adding she was unaware of an incident where R5 had been sent to a medical appointment unsupervised. HUC-A voiced someone should be present so they are supervised. When interviewed on [DATE], at 12:09 p.m. the HandiVan driver (HVD) stated he picks residents up from the nursing home and typically is given an envelope which he provides to the reception desk at the clinic or hospital. He expressed his service was basically a desk to desk service, and someone from the clinic takes over after he checks them in. HVD voiced family, at times, will meet residents from the nursing home at the clinic; however, it was only maybe ,[DATE] (percent) of the time. HVD verified he does not remain with the person while they're at the clinic, and if no family is present, he leaves then let's the resident see the physician. HVD stated he recalled a hair memory of the incident with R5 and, from what he could recall, thought he dropped him off at the clinic on [DATE], and R5's son or responsible party was not there so he brought him inside, but did not remain with him. Further, HVD stated since the incident with R5, he had never been contacted by the nursing home to discuss the situation or revise any procedures to ensure residents are met by family or kept safe when left unsupervised at the clinic. On [DATE], at 1:25 p.m. registered nurse unit manager (RN)-B was interviewed. RN-B explained family was always able to attend appointments with residents; however, added a lot of the times they do go alone. RN-B voiced the HandiVan driver(s) typically waited for the residents at the clinic to her understanding, and added once they're checked in to the clinic appointments, the resident' safety and care planning becomes the clinic's responsibility and not the nursing homes. RN-B stated there were some residents on the locked memory care unit she would hesitate to send alone to appointments, and voiced while the HUC and her do speak about residents and appointments, there was no formal system to decide who needs supervision and who doesn't for appointments. RN-B added, It's not our policy to make sure somebody's with them. RN-B then reviewed R5's incident from [DATE]. RN-B explained R5 had dementia and could self-propel in his wheelchair. RN-B added, at times, she recalled R5 as someone who did become confused and search for people to take him to various places. RN-B stated R5 was a resident who probably should have had family or a staff member present with him at off campus appointments as he would likely not give the physician accurate information on his condition(s). RN-B stated she didn't think much, if any, information on activities of daily living (ADL) assistance or supervision interventions (i.e. to prevent falls or elopements) were sent with residents on appointments adding, We don't do a whole lot of that kind of stuff. RN-B recalled R5's [DATE] appointment and stated the clinic had contacted her via telephone when he arrived and she remembered them being upset and questioning why R5 was at the clinic. When questioned on her follow-up actions to ensure a similar situation like R5's incident on [DATE] did not reoccur, RN-B stated she did probably nothing; however, in hindsight, should have brought the clinic' concerns to someone's attention so they could review their system for sending people to appointments and make sure they're supervised appropriately. On [DATE], at 2:26 p.m. the director of nursing (DON) and RN-B were interviewed. The DON voiced the nursing home's responsibility was to setup the appointment and arrange transportation and she cannot verify if anyone from the nursing home contacts family to ensure they will be attending with the resident or not. DON added, I assume they would, and she felt that was occurring. RN-B and the DON verified they had not reviewed their systems or procedures for sending residents to appointments and ensuring care is coordinated and supervision is provided. The DON voiced she didn't know this was a thing and had we known she would have acted on it and maybe put something in place. A facility policy on supervision of residents while at appointments was not provided.
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to comprehensively reassess and develop interventions to reduce behaviors and promote well-being for 1 of 2 residents (R1) reviewed who displayed exit seeking and delusional behaviors which were not effectively addressed. Findings include: R1's significant change Minimum Data Set (MDS), dated [DATE], identified R1 had short and long-term memory impairment along with severely impaired cognitive skills for daily decision making. The MDS identified R1 demonstrated behavioral symptoms (i.e. hitting or scratching self, public sexual acts, screaming) during the review period; and the Care Area Assessment (CAA) for cognition and behavioral symptoms were listed as being triggered to be completed. R1's care plan, last revised 5/5/20, identified R1 received mood stabilizing medication(s) and listed targeted behaviors which included anger, restlessness, disrobing in public and repeated statements. A series of goals were listed for R1 which included using less medications and having less than two reports of anxious verbalizations daily. The care plan listed several interventions to meet the established goals which included documenting the resident's behaviors and mood, intervening as needed, and providing 1:1 visits or reassurance to her when distressed. R1's progress note, dated 10/28/19, identified R1 was being reviewed for a significant change in status

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) assessment. A note was completed by registered nurse unit manager (RN)-B which identified, Behavior: per the Target behavior charting crying was reported on 1 day. Verbally exhibiting anxiety was reported on 5 evenings with redirection and offering a snack or activity not being effective. Inability to sleep was reported X 5 days with reading material, TV, and snacks not being effective. Delusional comments reported daily with redirection and 1-1 visits not being effective. Exit seeking reported on 2 days with redirection and 1-1 not being effective. R1's subsequent progress note(s) were reviewed and identified the following: On 11/17/19, R1 had a verbal altercation with another resident. On 11/27/19, R1 was recorded as being, .aggressive towards other residents this shift. Resident has increase (sic) anxiety, grand thoughts, and cursing. PRN (as needed) administered, which was somewhat effective. Further, on 12/7/19, R1 was attempted to go into other resident' rooms and when re-directed threw her coloring box on the floor and became upset. R1 was recorded as expiring on 1/16/20. R1's subsequent Target Behavior Monitoring flowsheets, dated 11/2019 to 1/2020, identified the following: November 2019: R1 had five episodes of exit seeking with each of the episodes having interventions completed, including coloring or taking off the unit, however, each time these interventions were recorded the behavior was recorded as, Unchanged. R1 had six episodes of crying and/or weeping recorded with interventions completed, including reassurance and offering snacks or activities, however, each time these interventions were recorded the behavior was recorded as, Unchanged. R1 had 10 episodes of verbal complaints of anxiety recorded with each of the episodes having interventions completed. However, again, all of these recorded episodes had the behaviors recorded as, Unchanged, despite the interventions. R1 had 13 episodes of inability to sleep recorded, each having interventions listed which included massage, warm packs and snacks; however, again, all of these episodes recorded the behavior as, Unchanged, despite the interventions. Further, R1 had 22 episodes of delusional comments recorded with interventions being completed, including redirection and 1:1 visits, however each time these interventions were recorded the behavior was recorded as, Unchanged. December 2019: R1 had eight episodes of exit seeking with each of the episodes having interventions completed, including coloring or taking R1 off the unit, however, only one of the episodes was recorded as these interventions being effective. The other episodes recorded the behavior as, Unchanged. R1 had one episode of crying and/or weeping recorded with interventions completed, including reassurance and offering snacks or activities, however, these interventions were not effective and the behavior was recorded as, Unchanged. R1 had four episodes of verbal complaints of anxiety recorded with each of the episodes having interventions completed. However, again, all of these recorded episodes had the behaviors recorded as, Unchanged, despite the interventions. R1 had seven episodes of inability to sleep recorded with each of the episodes having interventions completed which included massage, warm packs and snacks; however, again, all of these episodes recorded the behavior as, Unchanged, despite the interventions. Further, R1 had 14 episodes of delusional comments recorded with interventions being completed, including redirection and 1:1 visits, however each time these interventions were recorded the behavior was recorded as, Unchanged. When interviewed on 7/16/20, at 10:17 a.m. nursing assistant (NA)-D voiced she recalled R1 and verified she resided on the Rum River Unit (locked memory care unit). R1 was able to self-propel in her wheelchair and often used, or attempted to use, other resident' bathrooms on the unit. NA-D recalled R1 had exit seeking behaviors and would often go around the unit kicking, pounding on doors and swearing. NA-D expressed R1 was re-directable at times, and if not, the staff would give her medications which helped most of the time. Further, NA-D stated any demonstrated behaviors from R1 were reported to the nurse(s) and added she felt R1's behaviors had gotten maybe slightly worse in the months leading up to her death in January 2020. R1's medical record was reviewed and lacked evidence R1 had been comprehensively reassessed and new interventions developed to reduce R1's identified behaviors despite the behaviors, and implemented interventions, being recorded in the progress note(s) as not effective. Further, the medical record lacked any evidence a CAA had been completed for R5's cognition and behavioral symptoms despite being triggered on the 10/28/19 MDS (See F636 for additional information). On 7/16/20, at 2:01 p.m. RN-B was interviewed and verified she was R1's care manager during the last months of her life at the nursing home. RN-B explained when a resident displays behavior(s), the staff attempt to observe the behavior and try to intervene by coming up with things they like. The unit used to have behavior meetings which helped in this process, however, they had not had a meeting for a few months as other things took priority. RN-B stated the facility typically accomplished the behavioral assessment by discussing them informally. On 7/17/20, at 9:08 a.m. a subsequent interview was held with RN-B. The last time R1 had been reviewed at the behavior meetings, at least to which RN-B could find evidence supporting, was in July 2019. They decided at the meeting to implement a calming activities intervention, however, RN-B voiced it had never been added to the care plan and should have been. Further, RN-B reviewed the medical record and verified there was no comprehensive assessment completed regarding R1's behaviors, despite the implemented interventions being listed as not effective and R1 continuing to have the same behaviors, and reiterated the system in place for assessing behaviors was the monthly meetings which had fallen by the wayside. A provided Behavioral Health Services policy, dated 5/31/19, identified behavioral health encompasses a resident's whole emotional and mental well-being. The facility was to use . a comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This assessment included obtaining information from medical records, family and/or the resident on usual patterns of cognition or mood and behavior; and, using the Resident Assessment Instrument (RAI) process including the MDS and CAA(s).
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review the facility failed to ensure all employees were being actively screened (other employees verifying temperature readings during the screening process) for the prevention and potential transmission of [MEDICAL CONDITION] (COVID-19), in accordance with the Centers for Disease Control (CDC) guidelines. This had the potential to affect all 92 residents currently residing in the facility at the time of the COVID-19 survey. Findings Include: A Centers for Medicare and Medicaid (CMS) COVID-19 Long-Term Care Facility Guidance, dated 4/2/20, identified procedures to be implemented to reduce the risk of COVID-19 transmission in a long-term care setting. This included, . every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked. On 7/17/20, at approximately 8:55 a.m. survey team entered facility through the main doors. At that time, survey staff observed three facility employees self screening with no verification of their temperature or COVID screening questions with another employee before entering the facility despite an employee being present at the screening table at the time (employee was screening survey staff). When interviewed on 7/17/20, at 11:49 a.m. dietary aide (DA-A) stated when arriving to work she answered questions and took her own temperature. DA-A said, There is always someone there to make sure you are doing the screening. DA-A stated she did not know of anyone needing to check my temperature. DA-A stated again she self-administered her own temperature and documented the results in the symptoms section of the screening process. When interviewed on 7/17/20, at 1:29 p.m. the director of nursing (DON) stated at the screening table there was always to be someone around to assist with the screening process. DON explained the screening process consisted of answering questions about symptoms and taking temperature. DON stated temperature monitoring was having someone else look at the temperature to verify result. DON stated there was a schedule for helping employees screen and someone was to be at the screening area to assist with all screening to verify information. DON stated she was not aware of employees not verifying temperatures. DON further explained employees had been educated on the screening process which included showing another employee verifying temperature results. Policy entitled COVID-19 Phase 2-All SNFs and all CO sites states, healthcare workers will complete a symptom screening form, including having their temperature checked .these forms will be reviewed by a facility designee prior to reporting to the resident care area.