| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245223 | A. Building<br>B. Wing | 10/08/2021 |

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| Bay View Nursing & Rehabilitation Center | 1412 West Fourth Street<br>Red Wing, MN 55066 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>43115<br><br>Based on interview and document review, the facility failed to notify the physician and resident representative after sexual assault for 1 of 3 residents (R2) who were reviewed for abuse.<br><br>Findings include:<br><br>The Facility Incident report dated 9/27/21, indicated R15 alerted staff that R1 had gone through her room, into the bathroom and into R2's room. Staff found R1 standing over R2 who laid in bed. R1 had his hand in R2's private area. When staff asked R1 why he was in R2's room, R1 stated because I wanted to. When asked if R1 touched R2, R1 stated yeah. Immediate action included to move R1 to his room, continue 15-minute checks for R1 and provide one to one supervision if R1 left his room. The report indicated the on-call registered nurse, administrator, state agency and director of nursing (DON) were notified.<br><br>During an interview on 10/5/21, at 1:35 p.m. R1's guardian stated on 9/28/21, the facility informed her that R1 touched a female staff member inappropriately therefore moved R1 to the 1st floor. R1's guardian stated she was not made aware of the sexual assault when R1 touched another residents vagina. R1's guardian stated she would want to be informed of sexual allegations made by R1 to other residents.<br><br>During an interview on 10/5/21, at 1:45 p.m. nurse practitioner (NP)-A stated she was not aware of the allegation on 9/27/21, when R1 was found alone with his fingers in R2's vagina. NP-A stated she would have wanted to been made aware so she could have performed an assessment on R1 and R2.<br><br>During an interview on 10/5/21, at 2:03 p.m. the director of nursing (DON) stated LPN-D oversaw the investigation on 9/27/21.<br><br>During an interview on 10/6/21, at 1:36 p.m. LPN-D stated he was in charge to report and investigate the allegation on 9/27/21. LPN-D stated after the incident he informed the on-call nurse, DON, administrator, and SA. LPN-D verified he did not inform NP-A or R1's guardian.<br><br>During an interview on 10/6/21, at 2:09 p.m. the director of nursing (DON) stated her expectation for allegations of abuse to be reported to the guardian or representatives, responsible parties, and the state agency.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility Resident Protection Plan dated 3/24/19, indicated the administrator or designee will inform the resident or resident representative of an incident and that the investigation was being conducted. The administrator or designee will inform the resident and/or responsible party of the investigation.<br><br>The facility Resident, Physician and Resident Representative(s) Notification policy dated 11/2016, indicated the facility will immediately inform the resident; consult with the physician/physician assistant (PA)/NP; and inform the resident representative when an accident involving the resident which results in injury and had the potential for requiring physician intervention. The facility must also notify the resident and resident representative when there was a change in resident rights. |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43115<br><br>Based on observation, interview and document review the facility failed to monitor, evaluate and intervene timely and protect 2 of 2 residents (R2, R11) from sexual abuse. This resulted in an immediate jeopardy (IJ) when the facility failed to prevent sexual abuse when R1 was found with hands in R2's vaginal area while R2 laid in her bed. This practice had the potential to affect 6 other female residents (R12, R15, R16, R22, R23 and R24) who resided on the same units as R1.<br><br>The IJ began on 9/5/21, when the facility failed to act on allegations of abuse, report to the physician and implement procedures to keep R2 and other female residents safe from sexual abuse. The facility administrator, director of nursing (DON), and assisted director of nursing (ADON) were notified of the IJ on 10/6/21, at 4:47 p.m. The IJ was removed on 10/8/21, at 11:47 a.m. but noncompliance remained at a lower scope and severity G, actual psychosocial harm for R2 as a result of the sexual assault, that is not immediate jeopardy.<br><br>Findings include:<br><br>R1's Face Sheet dated 10/11/21, indicated diagnoses of central nervous system disorder, problems related to lifestyle, and paranoid schizophrenia.<br><br>R1's admission Minimal Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment. R1 was independent in bed mobility, transfers, walking, and locomotion. R1 required an antipsychotic on a routine basis.<br><br>R1's care plan dated 9/16/21, indicated a known history of violent crime or physical aggression prior to admission. R1 had a psychosocial well-being problem related to a traumatic brain injury (TBI). R1 had<br><br>behavioral problems related to sexual inappropriateness. R1 required assist of two for cares due to sexual inappropriateness.<br><br>R1's progress notes, were reviewed from 1/12/21 through 8/24/21 and revealed a history of verbal aggression both towards staff and other residents.<br><br>-1/12/21, indicated R1 made inappropriate sexual comments about other residents.<br><br>-2/7/21, R1 asked staff where can I find some pussy around here? R1 told licensed practical nurse (LPN)-E I 'm gonna fuck you, I like what I see. LPN- E told staff they needed to keep an eye on R1.<br><br>-2/14/21, indicated R1 attempted to go into the shower room while a female resident was using it. R1 got verbally aggressive when staff redirected.<br><br>-2/23/21, indicated R1 was sexually inappropriate. R1 asked a staff member if she would kiss him. R1 told this staff member he was going to get her at some point that day and get what he wanted.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -2/24/21, a psychiatric (psych) visit provider note indicated R1 was sexually inappropriate with his behavior with female staff. R1 cornered a female staff in the elevator twice. These behaviors started around September 2020. R1 had a history to sell himself to different woman but no men.<br><br>-3/9/21,. indicated R1 was sexually inappropriate. R1 stated Is she a go? can I have her? R1 stated I'm gonna get me some of that pussy when he was redirected.<br><br>-3/11/21, indicated R1 spoke sexually to housekeeping staff. R1 stated I'm gonna do what I want . when staff reminded R1 that he cannot talk to others like.<br><br>-3/17/21, indicated R1 attempted to go into another (unidentified) resident's room.<br><br>-3/27/21, indicated R1 went to room a (unidentified) female resident's room and knocked on the door. R1 told staff his girlfriend lived there. R1 needed to be redirected by staff three times.<br><br>-3/28/21, indicated R1 went into a (unidentified) female resident's room and put his hand on her shoulder.<br><br>-4/6/21, indicated R1 attempted to go into another female residents' room. R1 stated that she was his friend, and he knew her.<br><br>-4/7/21, indicated R1 asked a female staff to come to his room so R1 could show her how he cared about her. The female staff member asked R1 to not talk that way. R1 told her he could say whatever he wanted and would get (that female staff) eventually.<br><br>-4/11/21, indicated R1 attempted to go into a (unidentified) female resident's room.<br><br>-4/11/21, indicated R1 was sexually inappropriate with a housekeeper.<br><br>-4/14/21, indicated R1 was sexually inappropriate and stated, I'm gonna make her my baby and I'm gonna have sex with her.<br><br>- 4/17/21, indicated R1 attempted to go into another residents room .<br><br>-4/19/21, indicated R1 made an inappropriate statement to a nurse practitioner (NP). R1 stated, She's my baby. She's mine. I'm going to make her my baby.<br><br>-6/15/21, indicated R1 was found in a (unidentified) female's room sleeping on the floor at 4:00 a.m. It was suspected that R1 was in her room for 3 hours and entered the room at 1:00 a.m.<br><br>-7/3/21, indicated R1 attempted to go into another (unidentified) female resident's room but was redirected by staff.<br><br>-7/25/21, indicated R1 attempted to go outside and told staff he was getting out of the facility to see his girlfriend in Louisiana. A wander guard was placed on R1's wrist and 15-minute checks were continued. It is unknown if these checks were implemented based on a potential elopement or if staff identified R1's increasingly alarming sexual behaviors.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -7/25/21, indicated R1 was sexually inappropriate with staff. During R1's shower, R1 asked an unidentified NA, Can we go get a room together. The progress note also indicated R1 motioned for an unidentified NA to get into bed with him. Twenty minutes later R1 came out of his room and put his hand on an unidentified TMA's buttock. The facility continued with 15-minute checks.<br><br>- 8/12/21, indicated R1 was sexually inappropriate. R1 tried to touch a staff members breast and stated someone should Go to bed with him.<br><br>-8/18/21, indicated R1 was moved to the 3rd floor west wing. There was no mention how staff determined a move to the west wing was safe or appropriate and considered the vulnerability of existing residents on that wing.<br><br>- 8/24/21, indicated R1 stated, I know that I am not allowed to fuss with the ladies or mess with them, I am sorry and promise not to do it again. I hear voices and they say that something bad would happen.<br><br>-9/5/21, at 8:50 p.m. R1 was noted to have bothered and approached R11. R1 wanted to push R11's wheelchair into his room and then into her room. Staff had to intervene. R1 could not be redirected and would not leave R11 alone. Staff noted more than once R1 held R11's hand, tried to help her stand and wanted R11 to go to his room. Staff had to separate R1 from R11. Staff had to bring R11 behind the nurses station to ensure R1 stayed a distance from R11. R1 sat in a chair which faced the nurse's station and stared at R11 for over an hour. R1 finally went to his room after he was instructed. R1 did not stay in his room and continued to attempt to enter R11's room. R1 was redirected two more times when he was found heading towards R11's room.<br><br>-9/9/21, R1's provider indicated a visit for inappropriate behaviors was performed. R1 was found in R11's bed the morning of 9/8/21. Staff reported R1 had been looking at her earlier and they planned to move R11. R1 and R11 were fully clothed. R1 was on top of the covers. Staff suspect R1 was in R11's bed for a few minutes, but it was unwitnessed to when he entered. The visit also indicated staff reported a female staff member accompanied R1 to an appointment, but the driver had to pull over the vehicle and tell R1 to stop being inappropriate. When R1 returned to the facility he backed the female staff member into a corner. R1 made intermittent inappropriate verbal sexual comments and had a history to sleep on the floor of another female resident.<br><br>-9/14/21, R1's physician indicated staff were to provide close supervision and protection for other residents due to multiple inappropriate behaviors.<br><br>-9/16/21, at 10:06 p.m. indicated R1 was noted to be in R2's room two times sitting on R2's chair while she was in bed and was redirected back to his room. 15-minute checks were completed and R1 was redirected back to his room.<br><br>-9/27/21, at 1:11 p.m. indicated R1 was found in R2's room during 15-minute checks. R1 sat on the bed while R2 was in a chair.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -9/27/21, at 8:27 p.m. indicated R15 alerted staff that R1 went through her room into the bathroom which was shared with R2. Staff found R2 lying in bed with R1 standing over R2. R1 had his hand in R2's private area. R1 was asked why he was in R2's room and responded, because I wanted to. When asked if he touched R2, R1 responded yeah. R1 was removed from R2's room. Staff continued 15-minute checks and whenever R1 left his room he would be on one-to-one supervision.<br><br>-9/28/21, at 12:45 p.m. indicated R1 was found standing in R2's room holding a water bottle and was redirected to own room. Staff completed 15-minute checks throughout the shift.<br><br>-9/28/21, at 1:54 p.m. indicated a transfer to the 1st floor [NAME] Wing.<br><br>9/29/21, R1's psychiatric provider note indicated R1 was found with his hands in R2's private area in R2's room. R1 was noted as stating, I know that I am not allowed to fuss with the ladies or mess with them. I am sorry and promise not to do it again. R1 stated he heard voices and they say that he should get evil; R1 saw people others cannot see.<br><br>R1' Behavior Monitoring logs identified on 9/16/21, indicated R1 was grabbing 10 times and needed redirection. On 9/27/21, R1 had inappropriate touching of others one time and was directed to bed. R1's behavior worsened.<br><br>The facility Incident report dated 9/27/21, indicated R15 alerted staff that R1 had gone through her room, into the bathroom and into R2's room. Staff found R1 standing over R2 who laid in bed. R1 had his hand in R2 private area. When staff asked R1 why he was in R2's room, R1 responded because I wanted to. When asked if R1 touched R2, R1 responded yeah. The facilities immediate action included to move R1 to his room, continue 15-minute checks for R1 and if R1 left his room to provide one to one supervision. The report indicated R1 was oriented to person and place; physiological factors included mental illness and forgetful. Witnesses included trained medication aide (TMA)-A, TMA-D and nursing assistant (NA)-B. The report indicated the on-call registered nurse, administrator, state agency and director of nursing (DON) were notified.<br><br>The facility Investigative Report dated 9/27/21, indicated R1 told staff he was visiting and touched R2. R2 communicated by shaking her head no at R1 but he kept touching R2.<br><br>R2<br><br>R2's Diagnosis Report dated 10/8/21, indicated diagnoses of flaccid hemiplegia affecting right non dominant side, speech and language deficit, muscle weakness, depression, and aphasia.<br><br>R2's quarterly MDS assessment dated [DATE], indicated severe cognitive impairment and was absence of spoken words. R2 responded adequately to simple, direct communication only and missed some part/intent of a message but comprehended most conversations. R2 required extensive assist with bed mobility, transfers; walked independently in her room but required supervision for locomotion.<br><br>R2's care plan dated 3/12/20, indicated a risk for vulnerability related to diagnoses of brain injury and impaired mobility. R2 did not speak.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | R2's Provider Visit dated 10/6/21, indicated R2 was seen for assessment after sexual assault from another resident [R1] who was found last week touching R2's genitalia. An assault assessment was performed on 10/6/21, once Nurse practitioner (NP)-A was notified 10/5/21, of the sexual assault. There was no pap smear or sexual transmitted disease (STD) testing completed given the time frame since the assault and the description of the assault.<br><br>R2's progress note dated 9/27/21, at 8:39 p.m. indicated R15 had alerted staff that R1 had gone through R15's room, into the shared bathroom and into R2's room. Staff found R1 standing over R2, who laid in bed. R1 had his had in R2's private area. R1 was removed to his room and put on 15-minute checks and one to one supervision when he was out of his room.<br><br>R15's Admission MDS dated [DATE], indicated had intact cognition and was an accurate historian.<br><br>R12's Face Sheet dated 10/8/21, indicated diagnoses of displaced fracture of medial malleolus of right tibia, anxiety, depression, hallucinations, psychosis, absence of above left knee, right artificial knee joint.<br><br>R12's annual MDS dated [DATE], indicated intact cognition. R12 required extensive assist with bed mobility; total dependent of staff for transfers; independent with locomotion on and off unit. R12 required a wheelchair for mobility.<br><br>R12's care plan dated 3/23/21, indicated risk for vulnerability related to physical mobility deficits.<br><br>R16's Diagnosis Report dated 10/8/21, indicated dementia, polyneuropathy, absence of below right knee, and depression.<br><br>R16's quarterly MDS dated [DATE], indicated moderate cognitive impairment. R16 was able to make herself understood and understood others. R16 required extensive assist with bed mobility, total assist to transfer, locomotion on and off unit, and required a wheelchair for mobility.<br><br>R16's care plan dated 7/15/21, indicated risk for vulnerability related to amputations with limited mobility, impaired cognition.<br><br>R22's admission MDS dated [DATE], indicated intact cognition. R22 had diagnoses of hip fracture and dementia. R22 made herself understood and was able to understand others. R22 required extensive assist with bed mobility, transfers. R22 was independent with locomotion on and off the unit. R22 had an impairment on one side of her lower extremity.<br><br>R23's significant change MDS dated [DATE], indicated intact cognition. R23 had diagnoses of arthritis and anxiety. R23 was able to make herself understood and understood others. R23 was independent with all activities of daily living's (ADLs) besides extensive assistance for toilet use.<br><br>R24's quarterly MDS dated [DATE], indicated moderate cognitive impairment. R24 made herself understood and was able to understand others. R24 was independent with ADL's.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 10/5/21, at 11:24 a.m. cook (C)-A stated R1 previously lived across the hall from R15 and R2. C-A stated on 9/27/21, R15 told her and TMA-A that R1 went into her room through a shared bathroom into R2's room. C-A stated TMA-A went into R2's room and found R1 hovering over R2. C-A also stated R2's gown was lifted with her brief on the floor. C-A stated she observed R1 was playing with R2 with his fingers in the direction of R2's vagina. C-A further stated R1 was known for sexual behaviors and R2 was not able to talk or yell for help. C-A stated R1 had aggressively come at her before but she could tell him no.<br><br>During an interview on 10/5/21, at 11:31 a.m. housekeeping (H)-A stated R1 liked to make sexual comments to staff but then moved on to vulnerable residents who can't talk. H-A stated she had caught R1 in bed with R11 on 9/8/21, and went to tell the nurse. H-A further stated on 9/8/21, R1 was spooning, cuddling, and rubbing R11's head. H-A further stated R11 was not able to defend herself and did not understand what was going on. H-A stated recently R1 was found sexually being inappropriate on 9/27/21, and H-B found R1 alone with R2 the next day on 9/28/21.<br><br>During an interview on 10/5/21, at 11:40 a.m. H-B stated she found R1 and R2 alone in R2's room on 9/28/21. H-B further stated she felt unsettled since there was an incident the night prior when R1 sexually assaulted R2. H-B stated she was concerned another sexual assault could have happened to.<br><br>During an interview on 10/5/21, at 11:47 a.m. TMA-C stated R1 was moved to the 1st floor due to a situation where he sexually assaulted R2. R1 had a history of sexual intentions with woman. TMA-C stated R1 was very aware when staff were watching him and was quick to make his move. TMA-C stated R1 knew he was being watched and took the opportunity whenever he could. TMA-C stated R1 currently was on 15- minute checks and had his room by the nurses station with hope it would be easier for staff to keep their eyes on R1.<br><br>During an interview on 10/5/21, at 12:18 p.m. NA-B stated R1 went into R2's room unsupervised on 9/27/21, between the 15 minute check when he helped R1 to bed. NA-B further stated the 15 minute checks for R1 were not affective therefore he put a linen cart in front of R2's room. NA-B stated after the incident NA-B went to speak to R1 in his room. NA-B stated he told R1 he was not allowed to be in R2's room. NA-B further stated R1 told him he touched R2 vagina and continued to touch her when R2 gestured no. NA-B stated R1 got upset with him, so he stepped out of the room and continued 15-minute checks. NA-B stated prior to the incident, R1 always stared at R2 since the moment R1 moved across the hall from R2. NA-B further stated to protect R2 he put a blue linen cart in front of R2's room and closed her door to prevent R1 from entering between 15-minute checks. NA-B stated prior to the incident on 9/27/21, he put the cart in front of R2s room but R1 passed through R15's room through the shared bathroom to get to R2.<br><br>During an interview on 10/5/21, at 12:37 p.m. R15 stated on 9/27/21, R1 came into her room wearing a brief. R15 stated she asked R1 what he was doing and R1 said he needed to use the bathroom and then went into the shared bathroom which connected to R2's room. R15 stated she went to tell the TMA-A that R1 came into her room as it was very odd. R15 further stated it creeped her out when he came into her room.<br><br>During an interview on 10/5/21, at 12:42 p.m. R1 stated he moved to the 1st floor recently since he got into a fuss with someone.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 10/5/21, at 12:47 p.m. LPN-F stated the nurses station was adjacent to the left of R1's room and to the right were all males. LPN-F further stated on the other side of the nurses station, just around the corner to R1's room were two female residents room (R12, R16). LPN-F stated currently R1 was not aware that R12, R16 were around the corner from him therefore staff tried to keep R12, and R16's door shut so R1 does not become aware they are there. LPN-F further stated R12 propelled herself around the unit but usually did not go down the hall where R1 resided.<br><br>During an interview on 10/5/21, at 12:55 a.m. R16 stated someone recently visited her while she was asleep. R16 further stated her neighbor, R12 had the same unidentified man. R16 stated it scared her when he came in this made her not feel safe.<br><br>During an interview on 10/5/21, at 1:01 p.m. R12 stated she had a visitor come in late at night and he liked to follow her. R12 stated she saw him every once and a while.<br><br>During an interview on 10/5/21, at 1:06 p.m. R1 stated he like to stay up half the night.<br><br>During an interview on 10/5/21, at 1:35 p.m. R1's guardian stated R1 was incarcerated for assault prior to his admission into Bayview. R1's guardian stated R1 discharged from the facility to a group home. R1 was hospitalized and the group home would not accept him back due to in inappropriate sexual behaviors towards females therefore came back to the facility.<br><br>During an interview on 10/5/21, at 1:45 p.m. NP-A stated she was not aware of the incident when R1 sexually touched R2. NP-A stated she was only aware of the incident when R1 got into bed with R11. NP-A stated she would have done an assessment for R1 and R2 if she was made aware of incident on 9/27/21.<br><br>During an interview on 10/5/21, at 2:03 p.m. the DON stated R1 was initially focused on R11 who was R2's roommate. The DON stated after R11 was moved, R1 continued to want to go into R11's old room and became focused on R2. The DON verified R1 was found standing over R2 and touching R2's vagina. The DON stated after the incident R1 was put on one to ones if he left his room until the next morning. The DON stated the facility continued with 15-minute checks when R1 was moved to the first floor by the nursing station. Down the hall from the nurses station was all males but two female residents lived around the corner from R1 and the nurses station. The DON stated there was always staff at the nurses station to intervene if R1 left his room.<br><br>During an interview on 10/5/21, at 2:22 p.m. TMA-A stated there had been an issue for sometime were R1 tried to get into R2's room. TMA-A stated prior to the incident on 9/27/21, R1 constantly tried to get into R2's room and was successful. TMA-A stated on 9/27/21, R15 came to her and told her R1 came into her room, went through the shared bathroom into R2's room. TMA-A stated she went straight to R2's room. TMA-further stated she saw R2's brief on the floor and R1's had his hand in R2's vagina. TMA-A further stated R2's facial expression appeared scared and uncomfortable when she walked in. TMA-A stated R1 should have been moved immediately instead of keeping R1 across the hall from R2. TMA-A stated R1 should not have been near R2 unsupervised again the day after the incident. TMA-A stated R1 will not stop and the females need to be safe. TMA-A stated R1 targeted R11, R13 and R14 prior to R2. TMA-A also stated R1 targeted woman who were not vocal. TMA-A further stated since R2 could not talk, there were times R2 walked out of her room and appeared uncomfortable when R1 went into her room unsupervised. TMA-A stated prior to the incident she had seen R1 try to get into R2's room at night.<br><br>(continued on next page) |

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| | 245223 | A. Building<br>B. Wing | 10/08/2021 |

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| Bay View Nursing & Rehabilitation Center | 1412 West Fourth Street<br>Red Wing, MN 55066 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an observation on 10/6/21, at 11:29 a.m. there were no staff at the 1st floor [NAME] nursing station. R1 was in his room alone.<br><br>During an interview on 10/6/21, at 12:55 p.m. LPN-C stated there was no way the night staff could keep an eye on R1, and night staff were not always at the nursing station. LPN-C stated the female residents on the first floor are not safe as there was not always a nurse at the desk especially in the evening and night. LPN-C further stated R1's room used to be on an all-male hall on the 3rd floor East, but he was still able to get to the female residents. LPN-C stated on 9/28/21, the morning after the sexual assault R1 was still able to get to R2 unattended. LPN-C stated there were two linen carts in front of R15 and R2's room to protect R2 from R1 from entering when she arrived the next morning.<br><br>During an interview on 10/6/21, at 1:36 a.m. LPN-D stated he had TMA-A interview R2 after the incident on 9/27/21, since R2 worked better with females. LPN-D stated when he asked R2 if R1 touched her, R2 responded yes.<br><br>During an interview on 10/8/21, at 9:38 a.m. NA-F stated there were five residents (R12, R16, R22, R23, R24) who reside on the 1st floor where R1 resided. NA-F stated R1 could go on the east and west side of the 1st floor if he wanted.<br><br>The facility Resident Protection Plan dated 3/24/19, indicated sexual abuse is non-consensual sexual contact of any time with a resident. Sexual abuse includes but was not limited to: unwanted intimate touching of any kind especially of breast or perineal area. Generally, sexual contact was nonconsensual if the resident either appeared to want the contact to occur but lacks the cognitive ability to consent or does not want the contact to occur. Sexual contact that results from threats, force, or the inability of the person to give consent and involving a range of activities, including but not limited to assault, rape, or sexual harassment.<br><br>The immediate jeopardy that began on 9/5/21, was removed on 10/8/21, at 11:47 a.m. when the facility developed and implemented interventions to prevent the potential outcome for female residents to suffer an unwanted outcome from R1. The facility started one to one supervision by a male caregiver for all shifts while social services worked to find an appropriate all male discharge location. R1 and R2 were assessed by NP-A, while R1 was seen by psychiatric services. Staff verified they received reeducation on abuse, monitoring and notification to providers, and guardian. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>43115<br><br>Based on interview and document review, the facility failed to thoroughly investigate an allegation of sexual abuse for 1 of 3 residents (R2) who were reviewed for abuse.<br><br>Findings include:<br><br>The Facility Incident report dated 9/27/21, indicated R15 alerted staff that R1 had gone through her room, into the bathroom and into R2's room. Staff found R1 standing over R2 who laid in bed. R1 had his hand in R2's private area. When staff asked R1 why he was in R2's room, R1 stated because I wanted to. When asked if R1 touched R2, R1 stated yeah. Immediate action included to move R1 to his room, continue 15-minute checks for R1 and if R1 left his room to provide one to one supervision. The report indicated R1 was oriented to person and place, Physiological factors included mental illness and forgetful. Witnesses included trained medication aide (TMA)-A, TMA-D and nursing assistant (NA)-B. The report indicated the on-call registered nurse, administrator, state agency and director of nursing (DON) were notified.<br><br>The Facility Investigative report dated 9/27/21, indicated R1 told staff he was visiting and touched R2. R2 communicated by shacking her head no at R1 but he kept touching R2. The report indicated TMA-A, TMA-D and NA-B were interviewed. The report had no indication other residents or witnesses were interviewed.<br><br>During an interview on 10/6/21, at 1:36 p.m. LPN-D stated he completed the investigation for the allegation on 9/27/21. LPN-D stated he interviewed TMA-A, TMA-D, NA-B, R1 and R2. LPN-D verified he did not interview other residents, staff, or witnesses.<br><br>During an interview on 10/5/21, at 2:03 p.m. the director of nursing (DON) stated LPN-D oversaw the investigation on 9/27/21.<br><br>The facility Resident Protection Plan dated 3/24/19, indicated an investigation was the process used to try to determine what happened.<br><br>An investigation would include who, residents' statements, involved staff and witness statements of events, a description of the resident's behavior and environment at time of the incident, observation of residents and behaviors during the investigation. |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>43115<br><br>Based on observation, interview and document review, the facility failed to designate a qualified person to serve as the director of food and nutrition services in the absence of a full-time dietitian. This had the potential to affect all 89 of 89 residents who required clinical nutrition services.<br><br>Findings include:<br><br>Food service director (FSD)-B's certificate for ServSafe Online Exam and Food Manger course dated 9/30/21. The certificate expires on 9/29/26.<br><br>FSD-B's resume undated, indicated high school education and some licensed practical nurse classes and training. FSD-B had no experience or education related to nutrition and food service.<br><br>During an interview on 10/7/21, at 11:20 a.m. The administrator stated the facility did not have a full-time dietitian and verified no one in the kitchen was certified to act as the director of food service. The administrator stated the director of food and nutrition services was FSD-B. The administrator stated FSD-B obtained her ServSafe certification on 9/30/21, and planned to sign up for the certified dietary manager (CDM) program through the University of North Dakota. The administrator also stated the facility was working on finding a preceptor for FSD-B to begin the program.<br><br>During an interview on 10/7/21, at 12:39 p.m. FSD-B stated she was the director of housekeeping, in charge of purchasing for the facility and two weeks ago also became the director of food and nutrition services. FSD-B stated she obtained her ServeSafe certification on 9/30/21, through a day course and test she completed online. FSD-B stated the course provided education on food safety but did not provide specific information related to therapeutic diets, diet textures or other areas related to clinical nutrition. FSD-B further stated they had a dietitian come one day every few weeks who she could email any questions to.<br><br>During an interview on 10/8/21, at 10:10 a.m. the director of nursing (DON) stated there was a consultant dietitian who came in once every few weeks. The DON verified FSD-B did not have the credentials to act as the director of food service but planned to.<br><br>The facility Food and Nutrition Service policy dated 11/2016, indicated if a qualified dietitian or other clinically qualified nutritional was not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who is a certified dietary manager; or certified food service manager; or has similar national certification for food service management and safety from a national certifying body; or has an associates or higher degree in food service management or in hospitality, if the course study included food service or restaurant management from an accredited institution of higher learning; and in states that have been established standards for food service managers or dietary managers, meets state requirements for food service managers or dietary managers; And receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44650<br><br>Based on observation, interview, and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission COVID-19 related to the proper utilization of personal protective equipment (PPE). This had the potential to affect all 13 residents who resided in the East Wing of the second floor, and 17 residents who resided on the East Wing of the third floor. In addition, the facility failed to ensure three hand sanitizing dispensers were functioning or filled with the appropriate hand sanitizer. This had the potential to affect all 13 residents who resided in the East Wing of the second floor.<br><br>Findings include:<br><br>R10 was admitted to the facility on [DATE]. R10's diagnosis included acute respiratory failure with hypoxia, compression of brain, pneumococcal meningitis, tracheostomy and ventilator. She was on quarantine 9/28/21 to 10/12/21 due to her recent admission and her COVID-19 vaccine course was incomplete.<br><br>On 10/5/2021, at 10:21 a.m. occupational therapist (OT)-C was observed in R10's room. There was a sign on the door indicating full PPE was required to enter the room. OT-C was in the room providing range of motion exercises on R10. OT-C was wearing eye protection and a mask. She saw the surveyor at the door and said she was supposed to be wearing full PPE. She then left the room and identified the PPE cart outside the door did not contain any gowns. She asked RN-A where more gowns were. She then donned the appropriate PPE. OT-C said she believed the expectation was they were to wear full PPE when entering the room. OT-C then reentered R10's room to complete range of motion exercises.<br><br>During an interview on 10/7/2021, at 11:37 a.m., the infection control registered nurse (RN)-B stated the expected was for staff always to were eye protection and mask while working on the floor and with residents. RN-B stated PPE requirements for quarantined or isolated residents are to wear mask, eye protection, gown, and gloves when providing direct cares.<br><br>R20 was admitted to the facility on [DATE]. R20's diagnosis included traumatic brain injury, fracture to the left humerus, fractured left scapula, fractured of 3rd cervical vertebrae.<br><br>On 10/7/2021, at 1:55 p.m. R20's was on the facility list of being on a 14-day quarantine from 10/4/21 to 10/18/21 as she was not vaccinated at the time of admission. There were no indicators outside of R20's room which would alert staff R20 was on quarantine. R20's door did not have a sign to identify R20 was to quarantine or staff were required to wear full PPE including eye protection, mask, gown, and gloves.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 10/7/2021, at 1:59 p.m. nursing assistant (NA)-A entered R20's room holding a coffee pot with only eye protection and a mask on, she did not don a gown or gloves. NA-A poured coffee for R20 and was touching her over-the-bed-table before leaving the room, she did not perform hand hygiene. NA-A was observed to go to the kitchen and set down the coffee pot. She touched multiple surfaces in the kitchen and removed coffee condiments. NA-A did not perform hand hygiene before entering or leaving the kitchen. NA-A then returned to R20's room without donning a gown, gloves or performing hand hygiene and gave the condiments to R20. She then exited R20's room without performing hand hygiene. During an interview with NA-A, NA-S said she was not sure if R20 was on quarantine. NA-A was informed R20 was a new admission. NA-A was not able to tell how someone was on quarantine. NA-A stated the, whole quarantine thing, ended a long time ago when people started getting vaccinated. NA-A wasn't sure when she was last educated on quarantine, infection prevention, or PPE requirements.<br><br>The facility Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures policy and procedure was last revised in July of 2020. The policy stated that for a resident with known or suspected COVID-19 staff are to wear gloves, isolation gown, eye protection and a N95 or higher-level respirator if available (a facemask is an acceptable alternative if a respirator is not available).<br><br>Hand Sanitizer<br><br>On 10/5/2021, at 11:20 a.m. RN-A was observed performing a suctioning procedure on R10. Writer used hand sanitizing dispenser when exiting the room and it was filled with soap, not hand sanitizer. RN-A used it as well and agreed it was soap in the dispenser and not hand sanitizer. RN-A stated it is the responsibility of housekeeping to replace the soap and sanitizer dispensers when empty. The dispenser contained Green Hand Wash<br><br>On 10/5/2021, at 11:30 a.m. the director of nursing (DON) was informed there was a hand sanitizing dispenser which contained soap instead of sanitizer.<br><br>On 10/7/2021, at 9:36 a.m. RN-A went into R10's room to provide cares with repositioning with one other unidentified staff member. Writer reached in and used sanitizer. NA-E stood out side R10's room. NA-E also used the dispenser. NA-E looked at writer and said, I think that's soap? NA-E and writer opened the dispenser together and discovered it was Green Hand Wash, not sanitizer. NA-E went and found some hand sanitizer and replaced the soap with it.<br><br>During an interview on 10/7/2021, at 9:49 a.m. housekeeping (H)-C and OT-C. was shown two hand sanitizer dispenser one with a large amount of buildup of gelled hand sanitizer which occluded sanitizer from coming out of the dispenser. OT-C said it is the responsibility of housekeeping to make sure they are filled and cleaned. H-C also confirmed housekeeping was supposed to refill and keep them clean. Surveyor also showed them another room where the dispenser was not working.<br><br>On 10/7/2021, at 1:42 p.m. writer received a return call from the facility supplier of Green Certified Hand Wash, Symmetry Medical Supplier. The soap was just common soap, it didn't contain any antimicrobial, antibacterial, or sanitizing properties. He said they did recently deliver sanitizer, so they should've had enough available.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures policy and procedure was last revised in July of 2020. The policy stated hand hygiene is to be performed before entering and leaving a room. Soap is to be used with water. |