STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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 to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on observation, interview and document review, the facility failed to ensure adequate supervision to prevent resident to resident sexual abuse when 1 of 2 resident (R1) who had a recent incident of resident-to-resident sexual abuse was found in the dining room rubbing a second female resident's (R2) genitals. This was an immediate jeopardy for R2 because this type of inappropriate and unwanted sexual contact would reasonably cause anyone to have psychosocial harm. It can be determined that the reasonable person in the resident's position would have experienced severe psychosocial harm including dehumanization and humiliation as a result of the sexual abuse. The immediate jeopardy (IJ) began on 4/13/24, at approximately 1:15 p.m. when R1 was left in the dining room unsupervised and found rubbing the genitals of a female resident (R2) who was unable to leave the area on her own. The IJ was identified on 4/19/24, and the director of nursing (DON) was notified of the IJ on 4/19/24, at 2:00 p.m. The immediate jeopardy was removed on 4/15/24, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. Findings include: R1's Resident Face Sheet, print date of 4/23/24, identified diagnosis that included Alzheimer's, dementia, anxiety and depression. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated he required assistance with transfer and self-propelled in his wheelchair. R1's Service Plan Modification Report, undated, identified inappropriate actions and touching female residents. R1's service plan identified non-pharmacological interventions added 4/3/24, that included document whereabouts for patterns of behavior, redirection, engage in reading books and watch movies. 4/17/24, service plan was updated to include the addition of antipsychotic medications. R1's nursing assistant care sheet undated, included monitor when out of room due to touchy with ladies, hourly checks, seat at dining table with other males and back toward crowd and not left alone in the dining room, when done eating move by nurse until all residents are out of the dining room. The care sheet further indicated during activities R1 would be placed by male residents and with staff. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation on 4/17/24, at 4:37 p.m. R1 was escorted to the dining room by staff. R1 was seated facing the back wall of the dining room with another male resident. R1 remained in the dining room supervised by staff until 6:16 p.m. when all other residents had left the dining room. R1's Progress Notes indicated the following: 3/29/24, Nursing assistant (NA) reported that she was going around getting residents from the unit down to the dining room before supper when she noted a call light and responded to the light. The NA went in to check the resident in that room and found R1 at the female resident's bedside in his wheel chair with his hands underneath the covers. R1 had his hands underneath her clothed buttocks. The NA assisted him in removing his hands from underneath the resident and brought him down to the dining room and reported to writer. The female resident in was in no distress and everything else in her room appeared untouched. R1 stated a few times as he was assisted to the dining room I didn't hurt her. R1 was assisted to his meal, then stated I just wanted to push my penis up against it to feel it. 4/7/24, R1 was seated in the chair in the corner of the room with only a shirt on. R1 stated he could get his penis up to belly button for writer. Writer assisted resident with putting brief, pants and socks on. While writer had resident standing, resident stated he could turn a little bit and slip it right in. 4/9/24 on 4/5/24 at a care conference, the administrator, DON, assistant director of nursing (ADON), social worker & nurse manager reviewed the 3/29/24, incident and interventions with R1's family member (FM)-A. Reviewed all the non-pharmacological interventions in place, reviewed the incident, investigation findings, and new interventions in place. Provided education about medication recommendations, specifically to address sexual urges, and explained side effect monitoring protocols. FM-A was able to provide additional items for redirection. Activities staff have modified their invitation request language and R1 had responded well with increased participation. 4/13/24, NA reported to staff that R1 was rubbing the genital area of a female resident (R2). NA-A stated R1 had his left hand on R2's upper thigh and his right hand was rubbing back and forth on her genitalia. No nursing staff were in the dining room at the time of the incident. R2 later reported it made her feel uncomfortable. R1 was placed on 15 minute checks until further notice. During observation on 4/17/24 at 4:43 p.m. R1 was seated in the dining room in his wheelchair facing the back wall of the dining room. R1 was seated with another male resident at the table. Outside the dining room a staff member was supervising from a large window. R2's Resident Face Sheet print date of 4/23/24, identified diagnosis that included Hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), schizoaffective disorder, depression, anxiety and aphasia (disorder that results from damage to portions of the brain that are responsible for language). R2's annual MDS dated [DATE], indicated a Brief Interview for Mental Status (BIMS) of 6 (severe cognitive impairment) and indicated she did not display behaviors. R2's Service Plan Modification Report indicated she preferred a stop sign to keep wanderers out of her room, added 4/4/24. R2's Resident Progress Notes indicated the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-4/13/24, Call made to R2's FM (family member) to update her on the incident that occurred. -4/15/24, R2 was asked about the events on 4/13/24, and stated I was scared but I don't let him bother me. I'll yell again. An untitled, undated facility investigation indicated 4/13/24, vulnerable adult report. The investigation indicated on call registered nurse (RN) notified DON that R1 was rubbing the clothed groin of R2 in the dining room just prior to the noon meal time. Staff report that they were following the care plan for R1 by having him in the dining room first and out last. Staff were transporting residents into the Blueberry dining room. When nursing assistant (NA) entered the dining room with another resident, NA saw R1 with his hand on R2's knee and the other hand on R2's groin, rubbing back and forth. The NA separated the two residents and transferred R2 to her room. The licensed practical nurse (LPN) on duty reported she implemented interventions of 15 minute checks on R1 and R1 would wait outside of dining room before and after meals until staff were able to sit with him in the dining room and take him back to the unit. Staff verified that care plan was being followed for R1 and that all stop signs were in place during the shift. Staff reported that they were transferring residents back to unit area after meal and that no staff members were present in the dining room at the time of the incident. R1 was interviewed and could not recall event. R2 was interviewed and stated I was scared but I don't let him [R1] bother me. I'll yell again. R2 was offered counseling. Review of resident to resident Incident on 4/13/24 lacked evidence R1 was adequately supervised to protect other vulnerable residents in the dining room. The Facility investigation outlined interventions that included: Hourly checks ongoing. R1 was moved to a table in the dining room with only males and not within sight of female residents. R1 will be placed outside the dining room by the nurse prior to start of meal and at the end of the meal while staff are transporting other residents back and forth to unit. During activities R1 will be stationed next to a staff member. Behavioral health physician met with care team to discuss R1. Medication management included the addition of antipsychotic medication. Protection for R2 included keeping her out of R1's sight line at meals and activities. Keep reasonable distance between R1 and R2. Ongoing use of mesh stop sign at room door. Protection for general population included changing dining room seating, R1 seated at table with other men and staff member in dining room when R1 was present in dining room. During interview on 4/17/24 at 1:47 p.m., registered nurse (RN)-B stated prior to the incident on 4/13/24, stop signs had been placed on the doors of the more vulnerable residents. RN-B stated immediately following the incident on 4/13/24, R1 had been placed on 15 minute checks but had since transitioned to hourly checks ongoing. During interview on 4/17/24 at 1:52 p.m., NA-B stated since the incident on 4/13/24, R1 had been placed on hourly checks. NA-B said R1 had to be the first one in the dining room and the last one out and could not be left alone and said if the NA's were busy he had to remain next to the nurse. During interview on 4/17/24 at 2:02 p.m., licensed practical nurse (LPN)-A stated when R1 was in the dining room he had to sit facing away from other residents and had to be in sight of staff of all times. LPN-A said R1 had to be the first one in the dining room and the last out for supervision. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 4/17/24 at 2:08 p.m., NA-C stated when in the dining room, R1 sat with other males. NA-C said she had received communication both written and verbal. NA-C said R1's location in the dining room had been changed and staff were to sit with him. During observation and interview on 4/17/24 at 7:27 p.m., R2 was in her wheelchair in her room watching television. R2 stated she remembered the incident from 4/13/24. When asked if she was afraid, R2 said well, not afraid, I was trying to get away. R2 further stated no staff were in the dining room and that the incident had made her uncomfortable. Lastly, R2 indicated, I just don't want to have him [R1] here. During interview on 4/17/24 at 7:39 p.m., RN-C stated R1 has supposed to be the first one in the dining room and the last out and said some of the residents had stop signs on their doors to keep him from wandering in. RN-C said since the incident on 4/13/24, R1 had a new spot in the dining room and had to be the first one to go in and the last one to leave. RN-C stated they were completing hourly checks on R1 had and to keep him in sight at all times. RN-C stated she had received the updates on a form for staff to read and sign during report. During an interview with the Corporate Nurse Consultant for the facility on 4/18/24 at 10:35 a.m., it was indicated that the intention of the intervention for R1 to be the first and last resident in and out of the dining room was to provide supervision by staff. During interview on 4/18/24 at approximately 10:40 a.m., The ADON stated since the incident occurred on 4/13/24, R1 was now seated at a table in the dining room with a male resident and his back to the rest of the residents. The administrator stated they had consulted with the psychiatrist and discussed and received consent for the addition of an anti-psychotic medication. Regarding supervision during non dining hours, the ADON stated when R1 was in common areas, staff had to keep eyes on him. During interview on 4/19/24 at 10:43 a.m., the DON stated the facility had not implemented a plan for 24-hour supervision of R1 because they did not think R1 would display inappropriate touching of female residents in the public areas of the facility. She further indicated that the intention of the intervention to have R1 to be the first and last resident in and out of the dining room was to ensure supervision while in dining room, which was not effective in preventing abuse on 4/13/24 because staff left him unsupervised. DON stated new intervention were introduced and staff had been immediately trained. Facility abuse prevention policy was requested but not received. The past noncompliance immediate jeopardy began on 4/13/23. The immediate jeopardy was removed, and the deficient practice corrected by 4/15/23, after the facility implemented a systemic plan that included the following actions: - The facility implemented a plan to ensure R1 was supervised while in common areas of the facility and without access to vulnerable residents. - Audits have been initiated to ensure R1 was not left unsupervised in dining room. - Facility updated R1's care sheet and care plan and provided education to staff on changes and updates.

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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. 35569 Based on interview and document review the facility failed to ensure resident to resident abuse was reported to law enforcement for 2 of 2 residents (R1, R2) reviewed for sexual assault. Findings include: R1's Resident Face Sheet identified diagnosis that included Alzheimer's, dementia, anxiety and depression. R1's quarterly Minimum Data Set (MDS) identified severe cognitive impairment and indicated he required assistance with transfer and self-propelled in his wheelchair. R1's Service Plan Modification Report identified inappropriate actions and touching female residents. R1's Progress Note dated 4/13/24, indicated nursing assistant (NA) reported to staff that R1 was rubbing the genital area of a female resident (R2). NA stated R1 had his left hand on R2's upper thigh and his right hand was rubbing back and forth on her genitalia. No nursing staff were in the dining room at the time of the incident. R2's Resident Face Sheet identified diagnosis that included Hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), schizoaffective disorder, depression, anxiety and aphasia (disorder that results from damage to portions of the brain that are responsible for language). R2's annual MDS indicated severe cognitive impairment and indicated she did not display behaviors. R2's Service Plan Modification Report indicated she preferred a stop sign to keep wanderers out of her room, added 4/4/24. R2's Resident Progress Note dated 4/15/24, indicated R2 was asked about the events on 4/13/24, and stated I was scared but I don't let him bother me. I'll yell again. During observation and interview on 4/17/24 at 7:27 p.m. R2 was in her wheelchair in her room watching television. R2 stated she remembered the incident from 4/13/24. When asked if she was afraid, R2 said well, not afraid, I was trying to get away. R2 further stated it had made her uncomfortable. During interview on 4/19/24 at 11:40 a.m. the director of nursing stated the incident had not been reported to law enforcement and said she was not aware of the requirement to report. Facility policy Reporting Reasonable Suspicion of a Crime dated 10/3/16, indicated the facility must report a reasonable suspicion of a crime against a vulnerable adult to the Minnesota Adult Abuse Reporting Center (law enforcement) and the state agency.