STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	05/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 report allegations of abuse timely for 1 of 3 residents (R1) reviewed for abuse. Findings include: An e-mail notification dated 5/22/2020, at 11:16 a.m. from LSW to director of nursing (DON) and human resources representative, included R1 came to me yesterday (5/21/2020) to discuss the CNA (certified nursing assistant NA-A). R1 stated to me that she is afraid of her. (NA-A) has never hurt (R1). The note indicated R1 had voiced other concerns such as NA-A was always in a hurry to get to break, NA-A had been more ornery, and NONstop (sic) talking. On one occasion (R1) told me about, (NA-A) just threw the washcloths at her and said wash your face. What I have heard; is she is hurried and rushed, short sometimes snappy responses My fear with this is creating another problem for the other resident's. Any suggestions? R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 did not have cognitive impairment, signs or symptoms of [MEDICAL CONDITION], or behaviors. According to the MDS, R1 required limited assistance from one staff member for personal hygiene and dressing. During an interview on 5/28/2020, at 11:14 a.m. R1 indicated she had a long history of working in health care, R1 stated I know why you're here, I know the drill, I know what to say. R1 said last week she had reported nursing assistant (NA)-A to the licensed social worker (LSW) for throwing a washcloth at her, and she felt threatened by NA-A. R1 said, she used to work in healthcare, knew how to act around residents, and knew what abuse was. R1 said she perceived NA-A's actions as abuse, didn't think NA-A intended to hurt her, R1 said she liked NA-A and thought NA-A was a good person. R1 also denied verbal/emotional/mental abuse and denied having a personality conflict with NA-A. When R1 was asked how the wash cloth was thrown at her and from where, R1 stated NA-A was standing in the doorway of the bathroom, as she sat on her bed (approximately 7-10 feet away), and NA-A had thrown the dry wash cloth at her. R1 denied any injuries as a result, and stated the facility had resolved her concerns by moving NA-A to work on another unit. During an interview on 5/28/2020, at 12:06 p.m. LSW stated R1 came to her last Friday 5/22/2020, and reported to her she was afraid of NA-A. LSW said she didn't ask R1 why she was afraid. LSW stated when she had asked R1 if NA-A had hurt her R1 didn't say anything. LSW said R1 told her that instead of handing her a wash cloth NA-A threw a washcloth at her and NA-A had not hurt her. LSW said she had not documented R1's report except in an e-mail which was sent to DON and HR. LSW said she had also called the DON to discuss R1's allegations as well. LSW added the allegations were not reported to the State Agency despite R1 reporting she was afraid of NA-A. LSW said she didn't think the allegations were reportable and the facility had not interviewed NA-A, other residents and/or staff to determine validity and if other residents were affected by NA-A. LSW said NA-A was reassigned to another unit and the plan was continue to monitor and check in with NA-A. LSW indicated she was the one who determined when vulnerable adult reports were made to the State Agency, however, on occasion it was an interdisciplinary team decision. During an interview on 5/28/2020, at 1:38 p.m. DON said LSW had contacted her on 5/22/2020, about R1's allegations against NA-A. DON confirmed the allegation was not reported to the State Agency and an investigation had not been completed. DON indicated that R1 wasn't necessarily scared of NA-A it was she worked to fast and R1 felt rushed. DON confirmed NA-A, other residents, and staff were not interviewed. Facility policy Reporting Abuse To State Agencies and Other Entities/Individuals dated 3/2016, directed staff to immediately notify the administrator followed by social services for allegations of abuse, neglect, injuries of an unknown source or abuse and then immediately reported to the State Agency.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 thoroughly investigate allegations of abuse for 1 of 3 residents (R1) reviewed for abuse. Findings include An Email notification dated 5/22/2020, at 11:16 a.m. from LSW to director of nursing (DON) and human resources representative, included R1 came to me yesterday (5/21/2020) to discuss the CNA (certified nursing assistant NA-A). R1 stated to me that she is afraid of her. (NA-A) has never hurt (R1). The note indicated R1 had voiced other concerns such as NA-A was always in a hurry to get to break, NA-A had been more ornery, and NONstop (sic) talking. On one occasion (R1) told me about, (NA-A} just threw the washcloths at her and said wash your face. The note further included LSW's perceptions, What I have heard; is she is hurried and rushed, short sometimes snappy responses My fear with this is creating another problem for the other resident's. Any suggestions? R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 did not have cognitive impairment, signs or symptoms of [MEDICAL CONDITION], or behaviors. According to the MDS, R1 required limited assistance from one staff member for personal hygiene and dressing. During an interview on 5/28/2020, at 10:32 a.m. registered nurse (RN)-A stated she was familiar with R1 and the allegations. RN-A indicated that she was not witnessed to NA-A mistreating/abusing residents. RN-A added sometimes NA-A has personality clashes with others. RN-A stated she was not aware of any other residents who had expressed serious concerns pertaining to NA-A's care. During an interview on 5/28/2020, at 10:58 a.m. NA-B stated R1 had reported to her about the washcloth incident, and that R1 didn't like NA-A. NA-B stated NA-A had a loud voice that carried and sometimes residents thought NA-A was yelling. NA-B also stated residents sometimes complaint that she moved too fast when providing cares. During an interview on 5/28/2020, at 11:14 a.m. R1 said last week she had reported nursing assistant (NA)-A to the licensed social worker (LSW) for throwing a washcloth at her, and she felt threatened by NA-A. During an interview on 5/28/2020, at 12:06 p.m. LSW stated R1 came to her last Friday 5/22/2020, and reported to her she was afraid of NA-A. LSW stated the facility had not interviewed NA-A, other residents and/or staff to determine validity and if other residents were affected by NA-A. During an interview on 5/28/2020, at 2:46 p.m. NA-A said her regular assignment had been changed when she came to work on 5/23/2020. NA-A said she only became aware of why the change when she asked the nurse. NA-A added the nurse updated NA-A about R1's allegations. NA-A recalled the day before (5/22/20), R1 was already upset because of the time she was woke up. NA-A stated when she went into the room, R1 was in the bathroom, and NA-A had helped R1 provide personal cares. NA-A stated R1 walked back to her bed and sat down, NA-A then asked R1 if she wanted to wash her face, R1 told her no. R1 asked NA-A to get an item for her. NA-A stated she then dropped the washcloths on the floor and walked out of the room, when she came back in the room, there was another aide in the room, delivered the requested item to R1 and left to go assist other residents. NA-A stated she never threw anything at R1. During an interview on 5/28/2020, at 1:38 p.m. DON stated LSW had contacted her on 5/22/2020, about R1's allegations against NA-A. DON confirmed the allegation was not investigated. DON confirmed NA-A, other residents, and staff were not interviewed. Facility policy Abuse and/or Neglect Investigation dated 3/2016, included All reports of resident abuse or neglect shall be promptly and thoroughly investigated.

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.