STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHFIELD A VILLA CENTER	**7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to timely notify a guardian of sexual abuse allegation for 1 of 3 residents (R3) reviewed for abuse. Findings include: According to Nursing Home Incident Reporting documents, a report was submitted to the state agency (SA) on 6/11/20, which indicated R3 was questioned if anyone asked to touch R3 inappropriately and R3 stated a man came and asked if R3 wanted to feel a man's penis in the hospital. The report indicated the guardian and nurse practitioner were informed immediately and staff were to monitor everyone going into R3's room. R3's quarterly Minimum Data Set (MDS), dated [DATE], indicated R3 had mildly impaired cognition based on a Brief Inventory Mental Status score of 12. R3 needed supervision with most activities of daily living (ADLs). R3 required extensive assist from staff for bed mobility. R3 had [DIAGNOSES REDACTED]. A review of the past three months of R3's medical record indicated no hospital stay. During interview on 6/17/20, at 10:49 a.m. R3 stated a man came in my room and wanted me to touch his penis. He was fully clothed. He was black. I told him no and he left. R3 added it happened at night about 20 days ago. R3's undated care plan indicated R3 was a vulnerable adult and indicated to notify the doctor if sensory perceptions worsen, psych consult as needed, remove residents that wander to (R3's) room immediately. The care plan lacked indication to notify the guardian. During interview on 6/17/20, at 11:11 a.m., nurse manager registered nurse (RN)-A stated on 6/11/20, during resident interviews related to a different investigation, R3 made the statement of allegation of attempted sexual abuse. RN-A updated the director of nursing (DON) immediately and updated the care plan. RN-A stated had not updated the guardian. RN-A was updated on the additional information R3 had reported on 6/17/20. During interview by phone on 6/17/20, at 1:12 p.m. guardian (G)-A stated was not aware of an incident from 6/11/20, nor any allegations of attempted sexual abuse. G-A stated they never notified me about it. G-A stated the facility had left a voicemail about ACP (associated clinic of psychiatry) today (6/17/20) and that was the only contact G-A had with the facility recently. G-A had planned to call the facility back today. G-A stated they (facility staff) need to notify the guardian right away for occurrences regarding abuse. G-A stated last year was sporadic for notification of changes, however this year had been improving. During interview on 6/17/20, at 3:30 p.m. the facility administrator stated staff have been trained to report immediately for allegations of sexual abuse. The guardian should be notified as soon as possible but within 24 hours. During interview on 6/17/20, at 4:00 p.m. the DON stated the guardian should be notified as soon as possible of an allegation of sexual abuse but within 24 hours. DON stated had called the guardian on 6/11/20, and left a message but assumed guardian had chosen not to call back. DON was unable to provide evidence the phone call was made or the guardian had been made aware of the incident on 6/11/20. During interview on 6/17/20, at 4:35 p.m. the DON stated their policy does not give a time frame for updating the guardian. DON stated best practice would be to notify the guardian right away, and to re-attempt if unable to contact. The facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property dated 11/28/17, directed the administrator or designee to inform the resident or resident's representative of the report of an incident and that an investigation is being conducted. Further, the administrator would keep the resident or his/her resident representative informed of the progress of an investigation, the findings and any corrective action taken. A policy related to timelines of notification for events and incidents was requested. The administrator stated they do not have that policy.

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.