STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MN VETERANS HOME MINNEAPOLIS	**5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417**

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 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 ensure a through investigation of an allegation of potential abuse for 1 of 3 residents (R1) reviewed for abuse. In addition, the facility failed to protect residents after an allegation of abuse occurred for 1 of 3 residents (R1) reviewed for abuse. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 had moderate cognitive impairment and [DIAGNOSES REDACTED]. The MDS identified R1 was independent with bed mobility, transfers, walking and toileting. The MDS indicated R1 required limited assistance with grooming and extensive assistance with dressing. The MDS identified R1 had not exhibited any verbal or physical behaviors. R1's annual Care Area Assessment (CAA) dated 2/20/20, indicated R1 had cognitive loss and confusion which affected his mood state and behaviors. The CAA identified R1 was independent with bed mobility, transfers, walking and required assistance with applying his socks and showering. The CAA indicated R1 had [MEDICAL CONDITION], rejected care at times and displayed verbally aggressive behaviors. R1's care plan revised 6/3/20, indicated R1 had short term memory impairment with episodes of confusion and depression. The care plan identified R1 had bruises to his left and right forearms and instructed staff to assess the bruises and to provide protection to the areas. The care plan instructed staff to ensure R1's safety and to re-approach later when R1 became verbally aggressive. The care plan indicated R1 was independent with bed mobility, transfers, walking, toileting and required assistance with applying compression stockings and showering tasks. Review of the facility's untitled incident report # , dated 6/3/20, at 2:30 p.m. identified R1 requested to speak to the nurse. R1 stated he wanted to report that a staff member caused two bruises on each of his arms which measured 5.5 centimeters (cm.) by 4.5 cm. on the left outer elbow and the other measured 6 cm. by 10 cm. with a 3 cm. raised area. R1 pointed to a nursing assistant (NA) nearby and identified it was her who caused the injury. R1 stated he wanted a report filed against her and wanted to speak to the top individuals about the incident. Review of State Agency (SA) Incident tracking form # 3 indicated the investigation of the incident had been completed on 6/9/20, at 5:44 a.m. The investigation summary indicated R1 approached nursing staff, removed his jacket to reveal bruising on his arms and stated he did that to himself. When staff asked him to wait until they were done with their duties at the medication cart, R1 then stated staff were responsible for the bruising. Staff asked R1 who was responsible for the bruising and R1 pointed to a NA. Staff completed an assessment of R1 and no other injuries were noted. The assistant director of nursing (ADON) interviewed the NA and she denied the allegation. The medical doctor (MD) and director of nursing (DON) were notified and the results of the investigation were inconclusive. The care plan had been updated to reflect two staff were to be present during all cares with R1. The NA was temporarily reassigned with plans to monitor her during cares and provide education as needed. The investigation lacked interviews with other residents and staff to determine if they had similar concerns and lacked actions taken to provide protection to R1 and other residents during the course of the investigation. On 6/11/20, at 8:22 a.m. NA-A stated R1 had cognitive impairment and was not a reliable historian. NA-A stated R1 was independent with most activities of daily living (ADL's) and needed assistance with applying his compression socks. NA-A stated last week R1 alleged NA-A hit R1 and caused the bruising to his arms and it was reported immediately. NA-A stated she did not hit R1 and did not know how his bruising occurred. NA-A stated R1 contradicted his allegation when interviewed by the ADON by informing her a white woman had caused his bruising when in fact NA-A was not a white woman. NA-A stated the nurse on duty and the ADON interviewed her and completed an investigation of the allegation. NA-A stated during the investigation process, NA-A was reassigned to another floor and confirmed she had not been removed from the schedule. NA-A stated she did not have increased supervision of the cares she performed when she had been reassigned. On 6/11/20, at 8:51 a.m. licensed practical nurse (LPN)-A stated R1 had cognitive impairment and felt he was not a reliable historian. LPN-A stated on 6/3/20, at 2:30 p.m. R1 approached the medication cart where LPN-A and another nurse were completing a narcotic count during shift change. R1 removed his coat sleeve from his left arm and stated he had done that to himself and pointed to a bruise on his left arm. LPN-A asked R1 to wait for them to complete the narcotic count and they would assist him and R1 then removed his right arm from the sleeve of his coat and pointed to a bruise on his right arm and stated staff had caused it. LPN-A stated she immediately reported it to registered nurse senior (RN)-A. On 6/11/20, at 9:00 a.m. RN-A stated R1 had a decline in the past year and indicated R1 had cognitive impairment and felt he was not a reliable historian. RN-A stated he was notified by LPN-A on 6/3/20, around 2:30 p.m. of R1's allegation. RN-A stated R1 was seated in a chair by the medication cart and had bruises to his left and right forearms. R1 stated NA-A had hurt him and caused the bruises and R1 wanted NA-A reprimanded for it. RN-A measured the bruises and noted no bleeding was present. RN-A notified the ADON and the DON. RN-A stated R1's care plan was updated to instruct staff to use two staff with all cares for R1. RN-A stated on 6/4/20, R1 was interviewed again by himself and ADON and R1 at that time indicated a white woman had caused his bruises and denied NA-A had caused the bruises. On 6/11/20, at 9:24 a.m. ADON stated she received a telephone call on 6/3/20, sometime after 2:30 p.m. and was notified of R1's allegation of abuse. ADON instructed staff to complete a report to the SA and instructed staff to reassign NA-A to work on another unit within the facility. ADON stated the next day on 6/4/20, at 6:45 a.m. she interviewed R1 and R1 stated a white woman had caused his bruising and had denied NA-A had abused him. ADON stated she completed the investigation which involved interviewing R1, RN-A, NA-A and LPN-A. ADON confirmed she did not interview other residents to see if they had similar concerns and verified NA-A was not removed from the schedule while the investigation was ongoing. ADON confirmed NA-A was not directly supervised when she was reassigned and verified NA-A had the opportunity to return to R1's unit while she had been reassigned. ADON stated no specific measures were implemented during the investigation to keep R1 and all residents residing in the facility safe. On 6/11/20, at 10:01 a.m. DON stated it was the ADONs who conducted the investigations into any allegations of abuse. DON stated she expected the investigation should include interviewing the resident, reviewing the plan of care, interviewing the staff involved, removing the alleged perpetrator (AP) from that assignment and interviewing other residents to see if they had similar concerns. DON stated ADON had completed the investigation and DON was not certain if ADON had interviewed other residents to see if they had similar concerns. DON stated in certain circumstances, AP who were facility employees would be suspended pending further investigation. DON stated if two residents had the same concern the AP would have been suspended however since R1 contradicted his allegation AP was not suspended in this instance. On 6/11/20, at 10:34 a.m. RN-B confirmed no coaching or additional education had been provided to NA-A. RN-B confirmed no care audits or supervision of NA-A's cares had been completed. Review of facility policy titled Vulnerable Adult/ Resident Protection Plan dated 11/19/19, indicated all reports of abuse would be promptly and thoroughly investigated. The policy identified while the investigation was being completed, suspected individuals would have their employment status reviewed and appropriate actions taken, after approval by the administrator or designee.

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.