STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

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 documentation review the facility failed to report allegation of potential physical abuse to the State Agency within 2 hours for 1 of 1 (R1) residents who alleged physical abuse from staff. Findings include: Review of the 7/23/20 at 12:08 p.m., State Agency (SA) report identified R1 reported during the night shift at 7/23/20 at 5:00 a.m., a dark-skinned bigger statured female nursing assistant (NA)-C came into her room and was rough with her. R1 reported that she quivered when she comes in. R1 identified she put her call light on as she needed to use the bathroom and was incontinent of urine. NA-C came into her room and shut off her call light. R1 told her she was wet. NA-C uncovered her to check and told R1 she was not wet and left the room. R1's 7/28/20, face sheet identified she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R1's 6/16/20, quarterly Minimum Data Set (MDS) identified R1 had moderate cognitive impairment. R1 required one to two staff for bed mobility, transfers, and toileting and was frequently incontinent of her bladder. R1's 7/28/20, care plan identified she required one to two staff for bed mobility. R1 received anti-psychotic medication daily for hallucinations and delusional disorder. Facility and family would meet with R1 as needed to address concerns. Staff were to monitor R1's mood and response to her medication. Staff were to offer support and listen to her concerns. R1's behaviors included she believed her husband was cheating on her, would cry, heard voices and would think it was her husband. R1 would dwell on someone cutting her legs off. Staff were to validate her feelings, provide 1:1 visits, and offer reassurance. R1 was able to express her needs verbally. R1 was at risk for bladder incontinence related to poor cognition and impaired mobility and used an incontinent product. R1 had chronic pain in both knees. Staff were to monitor for signs and symptoms of pain such as grimacing, moaning, or guarding and report to medical doctor as needed. Staff were to offer and attempt position changes and provide rest periods. Interview on 7/27/20 at 1:49 p.m., with R1 identified she had hip surgery and every time NA-C put a brief on her she would push on R1's side to turn her over and she did not seem to care. R1 identified when NA-C pushed on the hip that she had surgery on it felt rough and it would hurt. R1 identified when she was turned side to side by NA-C she was afraid that something would happen to her hip like the pin coming out. NA-C always looked grumpy when she helped her. R1 identified that NA-C has not helped her since she told someone about her and she now feels safer. Additional interview on 7/28/20 at 8:28 a.m., R1 identified her concern was that the night staff was supposed to check to see if she was wet, which they did check her but the staff was grumpy and told her she was not wet. R1 identified that this girl has not worked with her since she reported her. Interview on 7/27/20 at 2:33 p.m., with family member (FM) identified R1 has made a comment before that this one staff is rough when she moves her around in bed to change her incontinent product. FM identified R1 had identified she is not limber when she wakes in the night to turn and staff basically push her onto her side. FM identified R1 likes everyone else at the facility and likes the facility except for this one night staff person. FM identified she spoke to the social worker and activity staff about her mom's concern. FM identified she has not been updated on what the facility found out or what has been done. FM identified she was concerned if the staff found out that her mom said something the staff would take it out on her mom. Interview of 7/27/20 at 2:51 p.m., with licensed social worker (LSW) identified she was informed of R1 concern by the assistant director of nursing (ADON) the morning of 7/23/20 and spoke to R1 around 9:30 a.m. LSW identified that R1 identified a dark skinned bigger girl was rough with her. LSW identified she asked R1 what the staff did that was rough. R1 reported to her NA-C came into her room and shut off her light, uncovered her and told her she was not wet and left the room. LSW identified that R1 does often have delusional thoughts such as thinking her husband is here but not coming into to see her. R1 often thought he was having an affair with others here. LSW interviewed other residents NA-C assisted and the staff R1 initially reported this to in the morning. LSW identified she is usually the one who makes the SA reports but the director of nursing or administrator also make reports. LSW was unaware if the assistant director of nursing (ADON) was able to make SA reports. LSW identified the SA report was not filed until 12:08 p.m. that same day. Approximately 6.5 hours later. LSW thought immediate reporting was for egregious incidents, but after reviewing facility policy, confirmed the potential abuse should of been reported immediately within the two hour time-frame. Interview on 7/27/20 at 3:00 p.m., with ADON identified facility staff had notified her of R1's accusations on 7/23/20. R1 told NA-A and NA-B during morning cares that the night staff was rough with her. ADON identified she went to talk to R1 soon after. R1 told the ADON the girl was rough with her on the night shift. R1 makes accusations about her husband cheating on her and R1 has delusions and hallucinations. The ADON reported the allegation to the LSW who began an investigation. ADON identified that the LSW was responsible to make the report to the SA when she was onsite. Interview on 7/27/20 at 3:11 p.m., with the director of nursing (DON) identified she was made aware of R1 concern first thing in the morning on 7/23/20. The ADON and LSW talked about the incident and reporting. DON identified she then completed interviews with staff and determined no concerns were identified so NA-C was not suspended and returned to work that night. R1 had hallucinations and delusions and after her interviews, she did not feel there had been abuse. R1 seemed upset she was not changed when she felt she was wet. DON identified if a resident made an allegation of potential abuse, or was rough with them, staff were to be suspended pending an investigation. Staff were to file a Vulnerable Adult report and complete an investigation. Reporting of allegations was to occur within an hour or so. Interview on 7/28/20 at 8:42 a.m., with NA-C identified the DON had called her and asked her questions about cares with R1. NA-C identified that during the night of 7/22/20 into 7/23/20 she had checked on R1 two times once around 12:00 midnight R1 was wet and then again on last round and R1 was dry. NA-C identified during last rounds she told R1 what she was doing, raised her bed and checked her brief, NA-C identified if the line on the brief is yellow it means not wet and R1's line was yellow, so she did not remove her brief she lowered the bed and left the room. NA-C identified she asked the staff working in room next door if she had already changed R1 as she is usually wet each time you check her but that staff said no. NA-C identified she has worked with R1 since that day and R1 has never said anything to her during cares that she is rough. NA-C identified R1 has never asked her to slow down during cares or anything, the only thing R1 had ever told her is that she wants me to tell her if I am going to change her brief. NA-C identified R1 has always been fine when she has assisted her. Interview on 7/28/20 at 8:55 a.m., with licensed practical nurse (LPN)-A identified she worked the night of 7/22/20 into 7/23/20. LPN-A was unaware R1 had reported concerns with staff that night. LPN-A identified nothing unusual occurred during the night and staff assisted R1 as usual. LPN-A later became aware of R1's complaint when she was interviewed the next day. LPN-A had no concerns with NA-C or any other staff related to potential abuse. Interview on 7/28/20 at 9:08 a.m., with NA-A identified R1 reported to her around 7:00 a.m. on 7/23/20, while during cares the night before, R1 had put the light on to tell night staff she was wet and the night staff told her she was not wet. R1 reported the night staff was rough with her but did not identify which staff member it was. NA-A told the ADON. The ADON then spoke to R1 about the allegation. The LSW also interviewed herself that morning. Review of 2/19/18, Maltreatment Prohibition

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.

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Policy identified the definition of physical abuse occurred when an individual was injured hit, slapped, kicked, pinched, bitten, pushed, scratched, or burned. A resident complaining of staff treating them roughly was potential physical abuse and required a investigation. Staff were to report all allegations made involving suspected or known abuse immediately, as soon as possible, but no later than two hours after the allegation.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to update the care plan for 1 of 1 residents (R1) who did not want a specific staff person to assist her. Findings include: Review of the 7/23/20 at 12:08 p.m., State Agency (SA) report identified R1 reported during the night shift at 7/23/20 at 5:00 a.m., a dark-skinned bigger statured female nursing assistant (NA)-C came into her room and was rough with her. R1 reported that she quivered when she comes in. R1 identified she put her call light on as she needed to use the bathroom and was incontinent of urine. NA-C came into her room and shut off her call light. R1 told her she was wet. NA-C uncovered her to check and told R1 she was not wet and left the room. R1's 7/28/20, face sheet identified she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R1's 6/16/20, quarterly Minimum Data Set (MDS) identified R1 had moderate cognitive impairment. R1 required one to two staff for bed mobility, transfers, and toileting and was frequently incontinent of her bladder. R1's 7/28/20, care plan identified she required one to two staff for bed mobility. R1 received anti-psychotic medication daily for hallucinations and delusional disorder. Facility and family would meet with R1 as needed to address concerns. Staff were to monitor R1's mood and response to her medication. Staff were to offer support and listen to her concerns. R1's behaviors included she believed her husband was cheating on her, would cry, heard voices and would think it was her husband. R1 would dwell on someone cutting her legs off. Staff were to validate her feelings, provide 1:1 visits, and offer reassurance. R1 was able to express her needs verbally. R1 was at risk for bladder incontinence related to poor cognition and impaired mobility and used an incontinent product. R1 had chronic pain in both knees. Staff were to monitor for signs and symptoms of pain such as grimacing, moaning, or guarding and report to medical doctor as needed. Staff were to offer and attempt position changes and provide rest periods. No additional interventions had been updated after allegations of abuse had been made. Interview on 7/27/20 at 1:49 p.m., with R1 identified she had hip surgery and every time NA-C put a brief on her she would push on R1's side to turn her over and she did not seem to care. R1 identified when NA-C pushed on the hip that she had surgery on it felt rough and it would hurt. R1 identified when she was turned side to side by NA-C she was afraid that something would happen to her hip like the pin coming out. NA-C always looked grumpy when she helped her. R1 identified that NA-C has not helped her since she told someone about her and she now feels safer. Additional interview on 7/28/20 at 8:28 a.m., R1 identified her concern was that the night staff was supposed to check to see if she was wet, which they did check her but the staff was grumpy and told her she was not wet. R1 identified that this girl has not worked with her since she reported her. Interview on 7/27/20 at 2:33 p.m., with family member (FM) identified R1 has made a comment before that this one staff is rough when she moves her around in bed to change her incontinent product. FM identified R1 had identified she is not limber when she wakes in the night to turn and staff basically push her onto her side. FM identified R1 likes everyone else at the facility and likes the facility except for this one night staff person. FM identified she spoke to the social worker and activity staff about her mom's concern. FM identified she has not been updated on what the facility found out or what has been done. FM identified she was concerned if the staff found out that her mom said something the staff would take it out on her mom. Interview on 7/28/20 at 10:26 a.m., with DON confirmed no changes had been made to R1's care plan as it already addressed behaviors at the time of the incident. The DON was made aware of R1's concern first thing in the morning on 7/23/20. The ADON and LSW talked about the incident. The DON completed interviews with staff and determined no concerns were identified so NA-C was not suspended and returned to work that night. R1 had hallucinations and delusions and after her interviews, she did not feel there had been abuse. R1 seemed upset she was not changed when she felt she was wet. DON was updating R1's care plan to include two staff to assist her with cares at night to ensure she felt safe. Review of the 10/10/14, Care Plan policy identified staff were to identify resident needs, problems or concerns. The care plan was to include approaches to meet the identified goals including care and services that must be provided to meet those goals. Staff were to update the care plan on an ongoing basis as needs occurred. Review of 2/19/18, St. Maltreatment Prohibition Policy identified staff were to initiate immediate interventions to prevent any further occurrences or potential or suspect abuse. The interdisciplinary team would evaluate the current interventions and implement additional further intervention as needed.