STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	**06/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHVIEW ACRES HEALTHCARE CENTER	**2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118**

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 document review and interview, the facility failed to report an accusation of staff to resident rough treatment to the state agency for 1 of 3 residents (R3) reviewed for abuse allegations. Findings include: R3 significant change Minimum Data Set ((MDS) dated [DATE], indicated cognitively intact, with no delusions or hallucinations. R3's care plan dated 9/17/19, included, R3 was vulnerable and at risk for abuse related to cognitive impairment, dementia and need for assistance. Staff were directed to remove from potentially dangerous situations. R3's Incident Report dated 4/11/20, at 9:30 a.m. identified an allegation of physical abuse by a staff member, nursing assistant (NA)-A. The incident description identified R3 stated being roughly handled by NA-A and felt this caused a fall. R3 requested not to see NA-A in the room again. This allegation of rough handling had not been reported to the state agency. The facility policy titled Southview Acres Health Care Center Reporting of Maltreatment Policy and Procedure, revised 4/18/19, indicated any allegation involving abuse would be reported to the state agency not later than 2 hours after the allegation was made. During an interview on 6/15/20, at 4:16 p.m. RN-A verified when a resident makes an allegation of abuse it should be reported to the state agency and that the building charge would have been the one to report it. RN-A verified that due to not working that day it was not reported and assumed on Monday that the incident had already been reported. RN-B verified the allegation R3 made on 4/11/20, should have been reported to the state agency. During an interview on 6/15/20, at 4:04 p.m. the director of nursing (DON) verified when a resident makes an allegation of abuse it should be reported to the state agency. DON stated the expectation when a resident makes an allegation of being handled roughly, the nurse manager, building supervisor, or the social worker should report it 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 investigate an allegation of abuse and failed to protect residents during an investigation for 1 of 3 residents (R3) reviewed who had reported being abused. Findings include: R3 significant change Minimum Data Set ((MDS) dated [DATE], included, R3 was cognitively intact and required extensive assistance with transfers. The care plan identified R3 as vulnerable and at risk for abuse related to cognitive impairment, Dementia, and need for assistance. R3's care plan dated 9/17/19, indicated R3 would be kept safe and free from abuse. The care plan directed staff to remove R3 from potentially dangerous situations. A facility provided Incident Report dated 4/11/20, identified R3 had reported being, roughly handled by a staff member attempting to assist R3 to the bathroom which R3 alleges caused a fall at that time. Nursing assistant (NA) -A was removed from the room but allowed to work with other residents for the remainder of the shift and another caregiver was to provide cares for R3 at the time of the fall. The report included a review of the cause of the fall but did not include an investigation into the allegation of, rough handled by the staff member. The investigation failed to include any investigation into the allegation that R3 had been handled roughly by NA-A to include any interviews with R3, any other resident, any other staff members, observation of staff handling of R3, or any record review to determine if there were any other allegations against NA-A by other residents or staff. The investigation also failed to ensure NA-A did not have access to R3 or other vulnerable residents while investigating the allegation. The facility policy titled Southview Acres Health Care Center Reporting of Maltreatment Policy and Procedure, revised 4/18/19, indicated any allegation of abuse was to be reported immediately to Minnesota Department of Health (MDH) and an internal investigation of the incident completed which includes the employee in question interviewed and suspended, pending the investigation. During an interview on 6/15/20, at 4:04 p.m., Director of nursing (DON) verified that when a resident makes an allegation of abuse it should be reported to the State agency (SA) and investigated per the facility policy.

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