STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	**04/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

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 observation, interview and document review the facility failed to protect 1 of 2 residents (R1) during an investigation reviewed for abuse. Findings include: R1's [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R20 had intact cognition and indicated R1 needed extensive physical assistance of one staff for dressing, personal hygiene and toilet assistance. R1 was observed on [DATE]6/20, from 8:55 a.m. to 9:00 a.m. seated on the wheelchair at the dining room table. At 9:03 a.m. R1 completed eating breakfast independently, then cued nursing assistant (NA)-A to bring her back to her room. -At 9:05 a.m. NA-A was observed to wheel R1 to her room and then shut the door to provide cares. On [DATE]6/20, at 9:12 a.m. when approached and asked about the allegation, R1 stated She grabbed my neck and slammed me to the bed. My knees hurt and I told her and she kept doing it. She has no bedside manners. She was rough with me and would not listen when I told her my knees hurt. I was in pain when she was helping me it was just too rough. I did not feel safe when I was around her and they told me she would not work up here again. Her name is (NA-B). She is the only one here who is so rough when she is helping me. I feel safe now that she is not working here. I told one of the staff here last weekend and they came and told me they would move her from the floor that day and she would not work with me again. On [DATE]6/20, at 10:27 a.m. when asked about R1's allegation of abuse made by R1 on [DATE]1/20, day shift, licensed practical nurse (LPN)-A stated this was the first time I have heard of her saying anything about (NA-B) and she told me she grabbed her by the neck and slammed her into bed. I immediately reported this to the director of nursing. LPN-A also stated after she was made aware of the allegation she had NA-B swap floors with NA-C who was already on the first floor before NA-B was suspended. When asked how long NA-B was working on the first floor after the allegation with other resident(s), LPN-A stated she was not sure but thought it was about half hour to 45 minutes before she got direction from the director of nursing (DON) to send NA-B home. On [DATE]6/20, at 11:21 a.m. NA-B stated she and the other NA assigned on the floor had gone for break and when she returned to the floor, LPN-A told her R1 needed to be changed as she had an accident. NA-B also stated when she went to R1's room, R1 had asked her why her call light had not been answered as she needed assistance and she explained to R1 being on break and she apologized. NA-B then stated she then asked the other NA to assist to provide cares to R1 after other NA brought clean linen to the room. NA-B then stated after they completed the cares she had left to go downstairs and when she came back to the floor, the other NA told her she was in trouble. NA-B further stated at this time as she spoke to LPN-A at the nursing station, LPN-A asked her to move and work on first floor following the allegation. NA-B acknowledged after being moved to another floor after the allegation she did take care of and assist residents which included transferring R2 to bed using a Hoyer with NA-C before being suspended. On [DATE]6/20, at 11:39 a.m. the facility administrator acknowledged NA-B was supposed to be suspended immediately pending investigation as directed by the facility policy. When asked when she was made aware of the allegation, the administrator stated she was made aware by the DON on [DATE]1/20, Saturday at 12:00 p.m. as the DON was on-call. The administrator further stated she was not aware NA-B had been moved between the floors/units to work with other residents after the allegation. On [DATE]6/20, at 11:52 a.m. the DON stated to his knowledge the allegation happened at 11:30 a.m. somewhere that time and he was notified within 15 to 20 minutes. The DON went on to state he had spoken to LPN-A to make sure R1 was safe and at the time a skin assessment was completed and then he directed LPN-A to send NA-B home. When asked what time he was made aware of the allegation of abuse, the DON stated LPN-A had made him aware through text message at 11:37 a.m. The DON stated he was not aware NA-B had been moved to work on another floor after the allegation and before being sent home pending the investigation. The DON acknowledged NA-B was supposed to be suspended immediately and was not supposed to be allowed to continue caring for other residents. On [DATE]6/20, at 12:00 p.m. the consultant registered nurse (RN) stated that is a breach of our policy; the staff was supposed to be suspended immediately. On [DATE]6/20, at 12:06 p.m. LPN-B verified after R1's allegation of abuse on [DATE]1/20, NA-B had been moved to work on the first floor before NA-B was suspended. The facility Abuse Prohibition/Vulnerable Adult plan policy revised 2/2018, directed staff for response/reporting: 2. Immediate supervisor will be notified immediately, assess the situation to determine if any emergency treatment or action is required. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. a. If this is staff to resident alleged or suspected abuse, the staff person will be immediately suspended until the investigation is completed.

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