STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JOHNSON MEMORIAL HOSP & HOME	1290 LOCUST STREET DAWSON, MN 56232

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 document review the facility failed to report an allegation of staff to resident physical and verbal abuse to the State Agency (SA) for 1 of 1 resident (R2) who reported allegations of abuse to the facility staff. Findings include: R2's admission Minimum Data Set ((MDS) dated [DATE], identified R2 was cognitively intact. However, R2 experienced hallucination and delusions during assessment period. R1 was independent with transfers and ambulation with walker. MDS identified R2 had two or more falls. [DIAGNOSES REDACTED]. Review of the 5/27/20, facility incident report identified during care conference R2 self reported she had fallen during the night. R2 identified she was cold so she got up to get a sweater out of her dresser and when she went to grab the dresser for something to hold onto she missed and fell over. R2 identified she yelled for help and when the staff person came in she made her get up on her own and when she went back to bed the staff person pushed her into the bed and covered her up. The report identified that immediate action taken had been to interview the charge nurse to see if there was anything in report about R2 falling. The progress notes for R2 were also reviewed with no mention of a fall. The report identified R2 mental status was oriented to person, there had been no predisposing environmental factors, but R2 was confused and had impaired memory. On 5/29/20, a report had been filed to the State Agency (SA) due to R2 stating the staff person who responded to her yelling told her to get up on her own and when she went back to her bed that person pushed her in the bed. The 5/29/20, note further identified a temporary care plan had been started to include two staff to go into R2 room during the night when she rings. The nurse was to document any hallucinations or confusion during the night for next two weeks. The report identified that family was notified on 5/27/20. The report identified that the primary MD and the administrator were notified on 5/29/20. Review of the 5/29/20, SA report filed at 3:15 p.m., identified on 5/27/20 at 1:00 p.m., during care conference R2 stated that she fell during the night when she got up to get a sweater. R2 identified she tried to hold onto her dresser and fell . R2 reported she yelled for help and when staff entered room she identified they told me to get up on my own. R2 identified it took her a while but she finally did it. When she was walking back to her bed she pushed me in the bed and covered me up. Report identified during care conference R2 was asked in she knew who the person was and she replied she knew who they were but did not know their name. Report identified R2's BIMS indicates cognitively intact at a score of 13, but had history of being moderately impaired and having daily hallucinations and delusions that are frightening to her. Report identified action taken was to have two staff go in room at night. R2's progress note dated 5/29/20, at 4:14 p.m. identified a family member called and requested the social worker (SW) talk to R2 about being fearful. SW visited with R2 in regards to being scared of a person. R2 reported to SW that she was scared when she comes in here and pushes me into bed and covers me up. Progress note identified SW asked if anyone harmed her physically. R2 replied she stands in the corner by the bathroom and yells at me. R2 reported she does not touch her. R2 did not know if she threatened her or was swearing at her. R2 reported she lays still so she can not understand her. R2 reported she does not want to bother her. R2 reported to SW she does not want her fired twice during conversation. The DON was notified of concerns. During interview on 6/1/20 at 1:30 p.m., social worker (SW) identified the facility had not completed a five day investigation as they had just reported last week. SW identified that the director of nursing (DON) was supposed to visit with the night staff. SW identified she visited with R2 on Friday 5/29/20 who had a history of [REDACTED]. SW had asked R2 about the person and R2 identified they came in and pushed me into bed and covered me up. R2 identified she did not want the staff fired. The family member (FM)-B was on the speaker phone for care conference, and called the SW on Friday 5/29/20 and asked the SW to visit with R2. R2 advised FM-B about the incident again. SW identified two staff go in with R2 during the night. R2 had a history of [REDACTED]. SW confirmed no one had followed up with R2 after the care conference regarding her accusation. SW confirmed she did not follow up. There were several staff in the care conference. When it was over registered nurse (RN)-A talked to the charge nurse to see if there had been anything in report about R2 falling. The charge nurse identified there had been no report of a fall, so the facility did not follow up. Typically the DON would talk to the staff involved and she would talk to the resident. During interview on 6/1/20 at 1:55 p.m., with RN-S identified during care conference R2 stated she fell and staff yelled at her to get up on her own. RN-A spoke to the charge nurse after care conference to see if there had been any documentation of R2 falling and nothing was found. RN-A identified on 6/1/20, she and the SW would complete the five day investigation. R2 said she knew who the staff person was but would not tell them. RN-A had not interviewed the night staff yet. RN-A identified if a resident accused staff of abuse she would call the DON or administrator. If she was unable to reach them, she would look at the policy. All nurses have the ability to report to the SA. The facility would normally report within the first 2 to 24 hours depending on the incident. During interview on 6/1/20 at 2:10 p.m., with licensed practical nurse (LPN)-A identified R2 was very confused and would often hallucinate. R2 thinks there is a stairway behind her mirror and a barn behind her door. LPN-A identified she did not believe that R2 fell as she did not think she could not have gotten back up on her own. LPN-A identified if a resident reported someone yelled or pushed them she would start an investigation and report that to the administrator right away. During interview on 6/2/20 at 12:30 p.m., with family member (FM)-B identified she was on the care conference call on 5/29/20 when R2 made accusation about staff. FM-B called the SW on 5/29/20 to let then know R2 had one again reported the incident to FM-B. R2 told her the same story that she told during care conference. R2 had mentioned in the past that someone was not nice to her but would never give specifics. FM-B identified she thought on 5/27/20 after R2 reported what had happened, the facility would of done an investigation. FM-B identified the SW did communicate again with FM-B later in the day on 5/29/20. The facility did begin an investigation at that time. During interview on 6/2/20 at 1:15 p.m., with DON identified she was notified on 5/29/20 R2 made accusations during care conference on 5/27/20. DON identified she was unsure why the incident was not reported on 5/27/20 with an investigation started. DON confirmed staff should have made a report and followed up with an investigation including interviewing the night staff. The DON's expectation would be for staff to file a report immediately and start an investigation if a resident accused a staff member of yelling or pushing them. Staff had just started interviewing the night staff yesterday 6/1/20, but did not have any documentation. The care plan had been updated to include two staff to go in to care for R2. Review of Johnson Memorial Health Services Abuse Prevention Plan dated 11/2019, identified all suspected maltreatment/mistreatment be reported to the SA in accordance with the law and this Abuse Prevention Plan Policy and Procedure. All alleged violations of abuse were to be reported to the administrator and SA immediately but no later than two hours.
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 perform a thorough investigation in a timely manner following allegations of abuse for 1 of 3 residents (R2) reviewed for abuse. Findings include: R2's admission Minimum Data Set ((MDS)

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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