STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245396	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C	525 WEST MAIN STREET MELROSE, MN 56352

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 physical abuse to the State Agency (SA) within two hours for 1 of 3 residents (R2) reviewed for abuse. Findings include: The face sheet indicated R2's [DIAGNOSES REDACTED]. The Medicare- 5 Day Minimum Data Set ((MDS) dated [DATE], indicated R2 was cognitively intact. Progress note on 7/9/20 at 1:15 a.m. indicated resident required staff assist of one to transfer to the bathroom. During a phone interview on 7/10/20, at 9:17 a.m. R2 stated she had a sore hip and nursing assistant (NA)-A shoved her onto the stool last evening. R2 stated she had never been afraid before, I think about that girl and it frightens me. During a phone interview with administrator (ADMIN) and assistant director of nursing (ADON) on 7/10/20, at 10:12 a.m. ADMIN stated a vulnerable adult (VA) report was not filed with the State Agency. LPN-A determined the incident was not abuse and the allegation was a result of confusion. Further, no injuries were noted. During an phone interview on 7/10/20, at 10:52 a.m. LPN-A stated R2 reported on 7/9/20 NA-A assisted her to the bathroom. NA-A had pushed her too harshly and she was now afraid of NA-A. R2 told LPN-A NA-A was trying to hurt her and has been out to get her for a long time. LPN-A consulted with RN-A and determined that the incident was not abuse rather R2 had a [DIAGNOSES REDACTED]. During a phone interview on 7/10/20, at 1:13 p.m. ADON stated LPN-A referenced resources provided on VA reporting and abuse prevention to determine the event was not reportable. ADON stated LPN-A followed appropriate steps and did enough to determine it was not abuse nor was it reportable. ADON stated the RN was in charge and was responsible to pull staff off the floor and ensure the safety of all residents. A VA report had been filed on 7/10/20 at approximately 12:20 p.m. after new information was gathered during a follow up interview with R2 when allegations were made that NA-A threw her onto the toilet and now had red marks on her back. During a phone interview on 7/10/20, at 1:51 p.m. RN-A stated she received a call from LPN-A on 7/9/20, at approximately 11:15 p.m. about an incident and was not sure what to do. RN-A interviewed R2. R2 reported NA-A had put the palms of her hands on R2's hip and pushed her as hard as she could. RN-A noted no injuries or spots. R2 reported she was currently had hip pain and was known to have chronic hip pain. RN-A stated R2 was upset and tearful. Further, R2 stated that this was the first time she had ever been scared of someone. RN-A stated she told LPN-A to file a VA. RN-A stated LPN-A was in charge of the front half and it was LPN-A's decision to file or not. RN-A stated it sounded kind of intentional. and she would have reported it. During a phone interview on 7/10/20, at 3:01 p.m. NA-A stated she checked on R2 and R2 was self-transferring to the toilet. NA-A placed her hand on R2's hip to guide her positioning. R2 did not indicate any pain or discomfort. NA-A left resident in bathroom and instructed R2 to use call light to notify staff. Prior to completing her shift, NA-A reported off to LPN-A that R2 had self-transferred. During phone interview on 7/10/20, at 3:24 p.m. ADON indicated the director of nursing (DON) was on call when staff had questions. However, staff did not call the DON. ADON and DON were notified via email by LPN-A on 7/10/20, at 2:45 a.m. LPN-A had left ADON a voicemail, however, ADON was unaware of the missed call until the following morning. ADON stated her expectation was for LPN-A to speak with the resident and anyone else involved in the situation which included NA-A. After ADON spoke with RN-A, ADON stated the incident should have been reported. During phone interview on 7/13/20, at 9:39 a.m. LPN-A stated she had consulted with RN-A the evening the incident occurred and we were on the border. LPN-A reached out to ADON and left a voicemail. LPN-A stated after re-education I should have made the VA report. During phone interview on 7/13/20, at 2:38 p.m. DON stated when staff were uncertain, a VA report should be filed to the State Agency. Further, when a resident stated fear it was the expectation a report would have been filed. The facility policy Vulnerable Adults- Abuse Prevention Policy- Long Term Care/Swing Bed Excluding Monticello Swing Bed dated 6/2020, indicated residents will be protected against abuse and neglect. The facility requires all alleged violations involving abuse, neglect, injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made. The policy gave the definition of physical abuse as the use of physical force that may result in bodily injury, physical pain or impairment. This includes, but is not limited to hitting, slapping, pinching, and kicking. The policy indicated the reporting procedure as all employees, contracted employees, students and volunteers will report alleged violations involving mistreatment, neglect, or abuse to the administrator of the facility and/or their delegated designee. Also, all suspected or known maltreatment will be immediately reported to MN Department of Health/ Office of Health Facility Complaints via the secure website. The facility policy indicated CentraCare Long-Term Care Facilities will have a person on duty and/or on -call at all times with delegated administrative authority to intervene in any situation to protect residents, remove any individual from the facility if necessary for the protection of residents or staff, call local law enforcement for assistance, and call 911 for any type of emergency assistance. The facility policy indicated the facility will complete an internal investigation: immediately remove any alleged perpetrator(s) from their duties; interview resident, staff, witnesses involved; review resident's medical record, all circumstance surrounding the incident, and incident reports related. The facility policy indicated all CentraCare- long term care facilities employees and volunteers receive mandatory annual in-service training on understanding their legal responsibilities regarding the Vulnerable Adult Act. All employees, students, and volunteers are informed of policy and procedures for reporting suspected cases of abuse and neglect upon new employee general orientation.

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.