STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELGRADE NURSING HOME	**103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312**

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 observation, interview and record review the facility failed to report an allegation of abuse to the state agency (SA) immediately, but not later than 2 hours after an allegation of abuse was made for 1 of 3 residents (R5) reviewed for abuse. Findings include: R5's Minimum Data Set (MDS), dated [DATE], indicated cognitive impairment and [DIAGNOSES REDACTED]. During an interview on 7/21/20, at 2:10 p.m. LPN-1 stated she had been trained on abuse and neglect. Further, LPN-1 stated she had witnessed abuse by a staff person poking a resident in the head during a family visit but failed to report the incident. LPN-1 stated I should have reported it last week. LPN-1 immediately went to the director of nursing's (DON) office and reported the incident. During an interview on 7/21/20, at 2:48 p.m. R5 stated she recently had an outdoor visit with family and R7. Further, R5 stated no one had ever poked her in the head and that staff have never hurt her. During an interview on 7/21/20, at 3:05 p.m. R7 stated he'd recently had outdoor visits with R5 and family members. R7 stated he felt safe in the facility. During an interview on 7/21/20, at 3:16 p.m., family (F)-2 stated she had been to visit R5 a couple times during the previous few days and had no concerns of abuse. During an interview on 7/21/20, at 4:10 p.m. F1 stated she had been to visit R5 on 7/5/20 and there had been no physical abuse by staff. During an interview on 7/22/20, at 9:30 a.m. the Administrator stated at about 2:47 p.m. on 7/21/20 the alleged perpetrator (AP) was suspended pending investigation. Further, the Administrator stated it was LPN-1 responsibility to file the report to SA within 2 hours, however, it was not completed until around 7:00 p.m. that night. Further, the Administrator stated the alleged incident had happened on July 5, 2020 during a family visit and was not aware of the reason why LPN-1 had not reported the incident earlier. During an interview on 7/22/20, at 9:47 a.m. the DON stated LPN-1 was responsible to file the report of alleged abuse on 7/21/20 within 2 hours of reporting it to her. However, the DON did not receive confirmation until 7:34 p.m. on 7/21/20 and therefore the report was late. DON stated LPN-1 was immediately re-educated to report within 2 hours of an allegation and planned further counseling related to abuse policy for LPN-1. The facility's Abuse policy, not dated, stated the facility would ensure all alleged violations of abuse would be reported immediately, but not later than 2 hours after the allegation was made.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow care plan intervention of 2 staff to assist in transfer to reduce risk of or prevent a fall for 1 of 3 residents, (R1) reviewed for accidents. Findings include: R1's face sheet included [DIAGNOSES REDACTED]. R1's significant change Minimum Data Set ((MDS) dated [DATE], indicated R1 had moderate cognitive impairment and required extensive assistance from two staff for transfers and bed mobility, he was not able to ambulate. R1's activities of daily living (ADL) Care Area Assessment (CAA) worksheet, dated 1/22/20, identified R1 required extensive assistance with transfers. The CAA for falls indicated R1's strength and balance was moderate to poor in the upper and lower extremities. R1's care plan dated 4/13/20, indicated R1 had an ADL self-care performance deficit related to bilateral lower extremity weakness, activity intolerance, deconditioning, impaired balance and poor motivation towards independence. R1's care plan, revised on 2/17/20, indicated R1 required assist of two between bed/wheelchair/recliner/bedside commode. The care plan further indicated, resident has a history of leaning to the right. R1's progress note dated 4/14/20, reported a staff was transferring R1 from recliner to wheelchair using gait belt. Resident slipped while wearing gripper socks and slippers and was lowered to the floor by staff. Per incident report dated 4/14/20, R1 was transferred with one staff assist instead of two staff as noted was his need in the care plan. The progress note further indicated R1 stood, but was unable to step and pivot, his legs and knees became weak and was lowered to the floor. R1's progress noted dated 4/15/20, identified R1 was lowered to the floor during transfer. Care plan stated, R1 required two assist for transfer, only one assist was used during transfer. Nursing assistant (NA-A) was standing on his right side and wheelchair was locked in place on his left. Electric recliner was raised up to standing position. Extensive assist used to help to standing position with gait belt (a safety device used to help someone move). R1 grabbed his walker. He was able to lift his feet to pivot transfer to wheelchair, his knees and legs gave out due to weakness. R1 grabbed for the side of the wheelchair and disengaged the brake. NA-A lowered him to the ground. During interview on 7/22/20, at 12:01 p.m. director of nursing (DON), confirmed at time of fall, R1 was care planned to receive assistance from two staff for transfers. She further confirmed that R1's care plan was not followed at the time of his fall, as he received assist from one staff for the transfer. DON stated the overnight nurse printed a document each night which provided information with resident changes. This was given to the staff at the start of their shift. Furthermore, the staff had access to the care plan for each resident. Staff were also alerted of changes to resident needs when they logged into the computer, which they did at the start of their shift. DON stated she provided staff with re-education, but did not complete a re-education form as it was verbal. During interview on 7/22/20, at 2:34 p.m. NA-A, stated she transferred R1 from his recliner to his wheelchair using his gait belt. NA-A stated she did not ask for help from another staff member. R1 was lowered to the floor when his legs gave out and he was not able to hold himself up. NA-A stated she called for assistance while she lowered him to the floor and again once he was on the floor. NA-A stated she checked the computer at the start of her shift for changes with R1 and didn't see any changes. The previous shift told her R1 had a good day and was doing good with his transfers so she thought she could transfer him by herself. NA-A stated she did not check his care plan before she completed the transfer. Facility fall policy, revision date 2/22/2018, did not address following care plan interventions to reduce risk of fall.

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.