STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MINNESOTA VALLEY HEALTH CENTER INC	621 SOUTH 4TH STREET LE SUEUR, MN 56058

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** - Some	**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 ensure all residents remained safe after an allegation of abuse was reported by resident (R1). The alleged perpetrator (AP) was allowed to continue working while the investigation was being completed. This had the potential to affect 30 of 30 residents in the facility. Findings include: R1's admitting medical diagnosis's dated 8/17/20, included cerebral infarction (stroke), [MEDICAL CONDITION] (paralysis of one side of the body), [MEDICAL CONDITION] disorder (extreme mood swings), and dysarthria (difficulty talking). R1's admission minimum data set (MDS) assessment dated [DATE], indicated R1 refused to complete the brief interview for mental status or the PHQ-9 (screening tool for monitoring and measuring the severity of depression), and documentation indicated R1 as short tempered and easily annoyed. R1's care plan dated 8/17/20, indicated mood may fluctuate due to the [DIAGNOSES REDACTED]. Further, the care plan documented R1 refused cognitive testing and a [DIAGNOSES REDACTED]. A progress note dated 8/20/20, at 9:47 a.m. directed staff to increase R1's [MEDICATION NAME] (mediation to help treat [MEDICAL CONDITION] disorder) due to experiencing a manic episode (a sustained episode of irritable mood). During an interview on 8/26/20, at 12:54 p.m. nursing assistant (NA)-A stated this was the first time she had taken care of R1. NA-A indicated R1 was resistive to cares and was angry during the cares that were provided. NA-A stated registered nurse (RN)-A approached her and instructed her to stay out of R1's room because an allegation of rough care was reported against her. NA-A was unable to identify what time this happened during her shift, but it was later in the evening. She was further directed to continue caring for the other residents in Meadow Hallway. During an interview on 8/26/20, at 1:27 p.m. RN-A stated R1 reported rough care to NA-B from NA-A cares on 8/21/20, at approximately 6:30 p.m. NA-B immediately reported the allegation to RN-A. RN-A immediately went to R1's room and asked her about the allegation and R1 reported that NA-A forcefully pulled her glasses off her face and was rough repositioning her in bed. RN-A called the on-call nurse, RN-B, and it was concluded that a vulnerable adult report should be filed. After the call with RN-B, NA-A was instructed to stay out of R1's room but continue with cares in Meadow Hallway. RN-A stated there was no discussion regarding NA-A going home early from her shift. During an interview on 8/26/20, at 2:46 pm RN-B stated after talking with RN-A it was decided to file a vulnerable adult report. RN-B instructed RN-A to keep NA-A out of R1's room for the rest of the evening and if NA-A works the weekend that she should not enter R1's room. A progress note dated 8/21/20, at 10:02 p.m., RN-A documented R1 reported to NA-B that NA-A was rough getting her up for supper and ripped the glasses off her face. R1 stated the event occurred at approximately 6:30 p.m. that day. During an interview on 8/26/20, at 11:56 the director of nursing (DON) stated herself, the facility administrator and the licensed social worker were the team that investigated the rough care allegation. DON stated the police were immediately notified and NA-A was assigned to another hallway to be away from R1. DON verified that NA-A was allowed to stay and continue working and was not removed from the schedule while the investigation was being completed. The facility Vulnerable Adult Abuse and Neglect Prevention Plan policy last reviewed 4/23/20, directed, in the event of an allegation the alleged perpetrator would be escorted out of the facility in order to protect vulnerable adults and other residents of the facility. The facility Resident Rights policy last modified 2/01/17, directed that residents have the right to be free and protected from abuse.

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