STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Rehabilitation Center	1900 Sherren Avenue East Maplewood, MN 55109

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** 49338 Based on interview and document review, the facility failed to report an allegation of resident sexual abuse to the State Agency (SA) immediately, but not later than two hours after the allegation is made, for 1 of 1 resident (R1) reviewed who reported an allegation of sexual abuse in the facility. Findings include: R1's Minimum Data Set (MDS) assessment dated [DATE], indicated R1 admitted to the facility on [DATE] with diagnoses including non-Alzheimer's dementia, traumatic brain injury, seizure disorder, depression, post-traumatic stress disorder, and encounter for palliative care. R1 had moderate cognitive impairment and was dependent on staff for all hygiene cares, mobility, and transfers. R1's care plan focus dated 5/24/24, identified R1 as a vulnerable adult. It included an intervention dated 5/24/24, the local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. Nursing Home Incident Report #357954 submitted to the SA by the facility identified the date and time of submission as 10:35 a.m. on 9/16/24 and the submitter as the facility's administrator. The report noted at about 8:30 a.m. on 9/16/24, the administrator was notified by the assistant director of nursing (ADON) [R1] reported that she was raped at the facility to a family member who reported to R1's guardian who then reported to the facility. The date and time of the incident was identified as 5:24 p.m. on 9/14/24. The five day follow-up report submitted to the SA by the facility dated 9/20/24, noted on the night of 9/14/24 R1 made the statement that she was raped at the facility while on the phone with her [family member], with two staff members present. A document attached to the report, undated and unnamed, included an internal investigation was launched which led to the discovery of [nursing assistant (NA)-A] and agency [licensed practical nurse (LPN)-A] being present during the time of allegation on 9/14/24. (continued on next page)

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.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/24/24 at 7:33 a.m., NA-A stated she helped provide care for R1 on the evening shift on Saturday 9/14/24, but was not R1's assigned NA. She stated she was helping R1 make a phone call to a family member because R1 was upset and phone calls had helped calm her in the past. NA-A stated while R1 was talking on the phone to a family member she stated, can you please call the police for me . then she said I have been raped, can you please call the police for me. NA-A noted R1's nurse LPN-A was present in the room as she had come to give R1 some pills and was standing there. NA-A stated she asked LPN-A if she heard what R1 said, and LPN-A said yes and asked R1 why she was making these allegations and then left the room. NA-A stated after exiting R1's room she asked LPN-A again if LPN-A heard what R1 said and LPN-A stated yes, she had heard everything. NA-A stated she then concentrated on providing cares for her assigned residents and I didn't do anything else because the nurse was right there . so I was thinking she is supposed to take measures after that, so I focused on my own residents. The nurse is the one that is supposed to make the report, since she was there it was her responsibility and not me as an aide. During an interview on 9/24/24 at 9:52 a.m., the director of nursing (DON) noted the facility's investigation identified NA-A and LPN-A as present at the time R1 made the allegation of sexual abuse on the phone and overheard it. The DON stated NA-A said she did not report the event because the nurse was present at the time and NA-A assumed the nurse was going to report it. The DON stated she spoke to LPN-A who confirmed she heard the allegation but didn't think it was real and didn't report it. The DON identified the SA requires such allegations be reported immediately, but not more than two hours after the allegation is made. The DON stated, staff became aware of the sexual abuse allegation on Saturday when it happened, it was heard by the nurse and the aide . it should have been reported immediately . the policy is that it has to be reported immediately . this was not reported timely. During an interview on 9/24/24 at 10:55 a.m., LPN-A stated she provided care for R1 on the evening of 9/14/24. LPN-A stated she entered R1's room to give her medications and NA-A was there helping R1 make a phone call. After giving R1 the medications, LPN-A noted she walked out and left NA-A and R1 in the room and went to prepare medications for other residents. LPN-A stated she was then passing by R1's room and when she [R1] was on the phone with [the family member] she said they raped me . I heard [R1] say something like they raped me as I was walking by. LPN-A stated after that I continued passing med[ication]s because I was already late passing med[ications]s . after that I did not actually do anything. Of course, I was supposed to report it. I know there was no excuse, but I got caught up with so many things . I did not talk to the aide about it or tell anyone . I did not report it on Saturday. During an interview on 9/24/24 at 12:58 p.m., the administrator confirmed he reported an allegation of sexual abuse to the SA on 9/16/24 because R1 reported a rape at the facility. The administrator confirmed staff initially became aware of the allegation around 7:20 p.m. on 9/14/24 though he was not aware of it until the morning of 9/16/24 around 8:45 a.m. The administrator stated It was not reported timely. My expectation and the policy is that it would be reported immediately . we have to report sexual abuse to the state [SA] within two hours. Facility policy titled Sexual Abuse Allegations Procedure dated 6/18/19, included: The Administrator, Director of Nursing, or Social Worker will notify Minnesota Department of Health immediately. This notification MUST be made as soon as possible after learning of the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Abuse Prohibition/Vulnerable Adult Policy dated 3/2024, included: All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin . Suspected abuse shall be reported to OHFC [Office of Health Facility Complaints] online reporting process not later than 2 hours after forming the suspicion of abuse.