STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Galeon	410 West Main Street Osakis, MN 56360

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. 49035 Based on interview and document review, the facility failed to report an allegation of abuse as required for 1 of 2 residents (R82) reviewed for abuse. Findings Include: R82's entry Minimum Data Set (MDS) included an entry date of 10/18/24. R82's Order Summary Report dated 10/30/24, included an order for Hospice. On 10/25/24, a report was filed with the State Agency which reported abuse was witnessed during a hospice aide visit on 10/25/24. The report indicated nursing assistant (NA)-B, a hospice nursing assistant, reported the abuse to registered nurse (RN)-A. During interview on 10/29/24 at 5:29 p.m., RN-A confirmed NA-B reported witnessing rough cares provided to R82. RN-A confirmed she had not completed a body assessment after receiving the report. RN-A stated she had spoken with someone at the facility about the alleged abuse, but did not remember who. RN-A stated she would typically report concerns about abuse to either the director of nursing (DON), administrator, or social worker. RN-A stated she could not remember reporting the concerns to any of the mentioned staff. During interview on 10/29/24 at 5:48 p.m., RN-B confirmed RN-A had not reported abuse to her. RN-B was informed of the concern of abuse during the team meeting the following morning. RN-B stated it was passed on during report that NA-B felt NA-A was rough with R82. RN-B was unsure if any additional follow up was completed. During interview on 10/29/24 at 6:18 p.m., DON stated she received a call from RN-C who reported an aide witnessed rough cares from a facility employee. DON was unable to recall what time she received the call. DON confirmed she did not file a report with the state agency about the alleged abuse. DON confirmed abuse should be reported within two hours of receiving the report. During interview on 10/30/24 at 2:30 p.m., administrator stated a thorough investigation should have been completed with any concerns of abuse. Administrator stated a thorough investigation would take two to three days to complete and the report of abuse should have been file prior to investigation. (continued on next page)

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

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(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	Facility abuse policy included all alleged violations involving abuse should be reported immediately, but no later than two hours after the allegation was made.

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(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 - Few	Respond appropriately to all alleged violations. 49035 Based on interview and document review, the facility failed to investigate an allegation of abuse as required for 1 of 2 residents (R82) reviewed for abuse. Findings Include: R82's entry Minimum Data Set (MDS) included an entry date of 10/18/24. R82's Order Summary Report dated 10/30/24, included an order for Hospice. On 10/25/24, a report was filed with the State Agency which reported abuse was witnessed during a hospice aide visit on 10/25/24. The report indicated nursing assistant (NA)-B reported abuse to registered nurse (RN)-A. During interview on 10/29/24 at 5:29 p.m., RN-A confirmed NA-B reported witnessing rough cares provided to R82. RN-A confirmed she had not completed a body assessment after receiving the report. RN-A stated she would typically report concerns about abuse to either the director of nursing (DON), administrator, or social worker. RN-A confirmed she had not spoken with the alleged perpetrator after the report of abuse. During interview on 10/29/24 at 5:48 p.m., RN-B confirmed RN-A had not reported abuse to her. RN-B stated she was informed of the concern of abuse during a team meeting the following morning. RN-B stated it was passed on during report that NA-B felt NA-A was rough with R82. RN-B was unsure if any additional follow up was completed. RN-B stated it was standard procedure to take a staff member off the schedule after a report of alleged abuse. During interview on 10/29/24 at 6:18 p.m., director of nursing (DON) stated she received a call from RN-C who reported an aide witnessed rough cares from a facility employee. DON was unable to recall what day or time she received the call. DON stated she had spoken with the alleged perpetrator within the hour of receiving the phone call. DON stated she did not speak with any additional staff members or residents to complete a thorough investigation. DON confirmed she had not attempted to speak with the aide who reported the alleged abuse. DON stated she had completed a skin assessment of R82's but had not documented the assessment. DON stated she should have documented the assessment because if it wasn't documented, it did not happen. DON stated she had handwritten notes regarding the incident, but was not able to produce them at the time of the interview. DON confirmed the alleged perpetrator continued to work after the report of alleged abuse. DON produced an undated, handwritten one page sheet of paper on 10/30/24. During interview on 10/30/24 at 2:30 p.m., administrator stated a thorough investigation should have been completed with any concerns of abuse. Administrator stated a thorough investigation would take two to three days to complete and would include interviews with other residents, mood/behavior monitoring and removing the alleged staff member from the schedule. Facility schedules indicated NA-A worked 10/25/24, 10/26/24, 10/29/24, and 10/30/24. (continued on next page)

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(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 - Few	Facility abuse policy included all alleged violations involving abuse should be investigated immediately. The investigation should have included resident's statements, involved staff and witness statements of events, a description of the resident's behavior and environment at the time of the incident, injuries present, and observation of resident and staff behaviors during the investigation. The alleged individual would be immediately removed.