

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Green Pine Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 427 Main Street Northeast Menahga, MN 56464	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35569</p> <p>Based on interview and document review the facility failed to timely report an allegation of staff to resident abuse to the facility administrator and the state agency for 1 of 3 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's Admission Record identified diagnosis that included Alzheimer's disease, depression, anxiety and dementia.</p> <p>A report to the state agency (SA) dated 8/29/24, indicated on 8/26/24, nursing assistant (NA)-A report to registered nurse (RN)-A while she was assisting R1 to get dressed, her bra was up over her breasts and NA-B walked into the room and stated oh, boobies, then walked over to R1 and flicked her breast up.</p> <p>During interview on 9/6/24 at 11:22 a.m., NA-A stated on 8/26/24, she and NA-B were assisting R1. NA-A stated R1's shirt was pulled up over her breasts as they were waiting for the trained medication aide to come in and apply powder under her breasts. NA-A stated NA-B stepped forward and with the back of her hand, lifted up R1's breast and made a sound effect. NA-A said when she asked NA-B why she did that, NA-B acted like it was no big deal. NA-A stated she felt like NA-B thought it was funny. NA-A said she felt it was very inappropriate and said it should not have happened. NA-A states she reported the incident to RN-B shortly after the incident occurred.</p> <p>During interview on 9/6/24 at 11:33 a.m., RN-B stated when NA-A reported the incident to her, she was rounding with the nurse practitioner so she reported the incident to RN-A. RN-B said NA-A reported to her while performing cares for R1, NA-B flopped her breast, not in a nice way, and made a comment about boobies and was saying boob, boob. RN-B stated she had told the other unit manager (RN)-A, but had not reported the incident to the director of nursing or the administrator. RN-B stated she was aware the timeframe for reporting allegations of abuse was two hours.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 9/6/24 at 11:48 a.m., the administrator stated she had been made aware of the incident by RN-A on 8/29/24, three days after the incident occurred. During a subsequent interview at 1:40 p.m., the administrator said when the incident was reported to her she asked RN-A and RN-B why they had not reported the incident when it happened. The administrator said RN-A said she hadn't thought the incident was anything until NA-A brought it up three days later. The administrator stated staff education had not been implemented following the late reporting.</p> <p>Facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 6/10/19, indicated suspected abuse shall be reported to the administrator and SA no later than two hours after forming the suspicion of abuse. The policy identified sexual abuse as non-consensual sexual conduct of any type with a resident.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>35569</p> <p>Based on interview and document review the facility failed to implement immediate protection of residents (delayed three days) following an allegation of staff to resident sexual abuse for 1 of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>R1 Admission Record identified diagnosis that included Alzheimer's disease, depression, anxiety and dementia.</p> <p>A report to the state agency (SA) dated 8/29/24, indicated on 8/26/24, nursing assistant (NA)-A report to registered nurse (RN)-A while she was assisting R1 to get dressed, her bra was up over her breasts and NA-B walked into the room and stated oh, boobies, then walked over to R1 and flicked her breast up. Facility Investigation submitted to the SA on 9/4/24, indicated NA-B had walked toward R1, took the back of her hand and lifted R1's breast and stated something like, Boing and let R1's breast fall. The report indicated when NA-A asked NA-B why she had one that, NA-B told her, Oh, I just seen a boob nonchalantly. The investigation indicated NA-B denied remembering what she had said, denied intending to humiliate R1 and denied that her intentions had been sexual in nature.</p> <p>During interview on 9/6/24 at 11:22 a.m., NA-A stated on 8/26/24, she and NA-B were assisting R1. NA-A stated R1's shirt was pulled up over her breasts as they were waiting for the trained medication aide to come in and apply powder under her breasts. NA-A stated NA-B stepped forward and with the back of her hand, lifted up R1's breast and made a sound effect. NA-A said when she asked NA-B why she did that, NA-B acted like it was no big deal. NA-A stated she felt like NA-B thought it was funny. NA-A said she felt it was very inappropriate and said it should not have happened. NA-A stated she reported the incident to RN-B shortly after the incident occurred.</p> <p>During interview on 9/6/24 at 1:40 p.m., the administrator stated she had been notified of the incident on 8/29/24, three days after the incident occurred. The administrator said NA-B had been suspended on 8/29/24, and said NA-B had worked between 8/26/24, and 8/29/24 when she had been suspended.</p> <p>Facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 6/10/19, identified sexual abuse as any non-consensual sexual contact of any type with a resident. The policy indicated when suspected abuse was identified, safety measures would be implemented to ensure the safety of the suspected vulnerable adult and other residents. Such safety measure may include moving a resident to another room or floor, providing staff supervision of resident, as needed, and separating the suspected perpetrator and residents which may include placing an employee on administrative leave until the investigation was completed.</p>		