STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245231	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLETON AREA HEALTH	**30 S BEHL ST APPLETON, MN 56208**

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 0689 **Level of harm -** 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 observation, interview, and document review, the facility failed to implement adequate supervision and safety measures to ensure residents were free from accident hazards, for 1 of 3 residents (R1) reviewed. This resulted in actual harm when R1 sustained a fall resulting in two fractures, while receiving therapy. Findings include: R1's admission record, dated 5/2/18, indicated R1 had [DIAGNOSES REDACTED]. R1's Morse Fall Scale, completed 5/7/20, indicated R1 had history of falling, had impaired gait, overestimates or forgets limits, and was categorized as, High Risk for Falling. R1's Safety Risk Assessment, completed 2/6/20, indicated R1 had a history of [REDACTED]. Also included, R1 was at risk for falls due to history of falls and declining cognition and mobility, and was no longer safe to transfer or ambulate on own. R1's quarterly Minimum Data Set (MDS), dated [DATE], indicated R1 had moderate cognitive impairment and required extensive assistance of two staff for bed mobility, transfers, walking in the room and corridor, dressing, and toilet use. The MDS also identified R1 was not steady, was only able to stabilize with human assistance during transitions and walking, and had functional limitation in range of motion in upper extremities on both sides. Also, included, R1 had no falls since the previous MDS assessment, completed 2/20/20 due to a significant change, which indicated one fall with no injury, two or more falls with injury, and one fall with major injury. R1's care plan, last revised 2/25/20, indicated R1 had a performance deficit with activities of daily living (ADL) due to declining cognition, [DIAGNOSES REDACTED]s, decreased mobility, generalized weakness, and chronic back pain, and required extensive assistance of two staff, with gait belt and four wheeled walker for transfers, and extensive assistance of two to three staff, four wheeled walker and gait belt, followed by wheelchair, when ambulating. The care plan also indicated R1 was at risk for falls due to history of falls with injury, declining cognition, and mobility, and needed assistance to stabilize. Review of R1's physician orders [REDACTED]. R1's Physical Therapy PT Evaluation & Plan of Treatment, dated 5/8/20, indicated [DIAGNOSES REDACTED]. Long-Term goals identified R1 would demonstrate ability to perform sit to stand from recliner with minimal assist of one, improvement in bilateral lower extremity strength in order to improve stability in stance, be able to stand without upper extremity support for at least 30 seconds without loss of balance, and would be able to ambulate at least 200 feet with CGA (contact guard assist-physical therapist needs to have one or two hands on patients body to help steady body or help with balance) to minimal assist with rolling walker and cues for anterior weight shift less than 25% of time. Review of the Physical Therapy Treatment Encounter Note(s), dated 5/14/20, indicated, Once standing (R1) is able to maintain balance with only CGA for several minutes. Also indicated, all activities with CGA to minimal assist at all times to avoid loss of balance, and R1 had most difficulty with retrobalance (loss of balance in backwards direction) requiring minimal assist to avoid loss of balance. Physical Therapy Treatment Encounter Note(s), dated 5/15/19, included R1 reported his legs were really sore today, and staff reported R1's knees buckled during a transfer after PT on 5/14/20, and it took three staff to keep R1 from falling. Physical Therapy Treatment Encounter Note(s), dated 5/18/20, included, R1 completed standing glute sets, on parallel bars, CGA on gait belt. PTA (physical therapy assistant) positioned in front of pt (patient); pt sustains falls when PTA steps back to switch position to side of patient. Also included, During standing glute sets pt sustains fall backward when PTA lets go momentarily to switch positions with pt having BIL (bilateral) HHA (hand hold assist) on bars. Patient was wearing a gait belt and until the fall PTA had been in CGA with pt. During an observation on 5/21/20, at 2:00 p.m. R1 was lying in the bed, resting. A sling was noted on R1's right arm/shoulder, and R1 indicated he had to wear a boot on his right foot. R1 stated, (PTA-A) was walking me and went to switch sides. I fell back. R1 stated he just wanted to get stronger so he can walk and indicated he wasn't sure what happened, he just felt himself go backwards and he hit the floor. R1 indicated he had a gait belt on and stated with tears in eyes, (PTA-A) felt bad, but she didn't do it. It was me. I should be able to stand. Review of the Patient Incident/Injury Report Form, dated 5/18/20, at 1:10 p.m. included R1 was working with PTA-A in the parallel bars in the facility rehabilitation room, positioned in front of him holding the gait belt, and R1 was holding onto each side of the parallel bars. PTA-A let go and stepped back as she was going to change position to stand at R1's side. R1 had loss of balance backwards and fell to the floor when PTA-A let go of the gait belt. Review of the Appleton Area Health documentation, dated 5/18/20, included X-ray results indicated R1 sustained a nondisplaced fracture of right fibula (long, thin and lateral bone of the lower leg) and nondisplaced fracture of right humeral neck (long bone of the upper arm that extends from shoulder to elbow) when he fell , and CT (computerized tomography) scan of the brain indicated no [MEDICAL CONDITION] (bleeding in head) or cranial fractures. During an interview on 5/21/20, at 9:55 a.m. PTA-A stated she was working with R1 due to him having poor balance and history of falls. PTA-A stated, on 5/18/20, she ambulated with R1 from his room, into the hallway. R1 wore a gait belt, used a four wheeled walker, and nursing assistant (NA)-A and restorative aide (RA)-A assisted. PTA-A stated, after approximately 75 feet, R1 wanted to sit in the wheelchair. R1 was pushed into the rehabilitation room and PTA-A allowed him to rest. RA-A and NA-A left the room to help another resident. After resting, PTA-A stated she assisted R1 to stand and positioned him inside the parallel bars. PTA-A stated she was standing in front of R1, holding the gait belt, having R1 perform different exercises. PTA-A stated R1 was in the middle of the parallel bars, and she let go of the gait belt momentarily to step around to R1's side, outside of the parallel bars. R1 fell backwards to the floor. PTA-A stated she should have had R1 sit prior to letting go of the gait belt, however, she had let R1's gait belt go in prior sessions and he had never let go of the parallel bars. PTA-A stated the first time she walked with R1 on 5/14/20, he was super staggering and unsteady. On 5/18/20, PTA-A stated, when she and NA-A and RA-A walked R1, he was not nearly as unsteady. PTA-A stated, I thought he was improving. I felt he was stable enough for me to walk around him. PTA-A stated, after R1's fall, her manager talked to her and, Going forward, if someone is unsteady or a balance patient, I would have a second person to steady, or I could have him sit first and then switch positions. During an interview on 5/21/20, at 10:14 a.m. physical therapist (PT) indicated he and PTA-A worked for a therapy agency, and they were contracted to provide therapy services to residents at the facility. PT stated he oversees PTA-A and had talked with her about R1's fall. PT stated he assumed, by PTA-A's description, that she had R1 in the parallel bars, working on balance, and probably had him standing in the middle, and then went out of the parallel bars to change positions when R1 fell . While in the rehabilitation room, PT demonstrated how he would work with a resident in the parallel bars, indicating he would typically have the wheelchair close, and would have the resident sit while he switched positions. PT stated he had not provided any re-education for PTA-A, because she had a manager that was responsible for doing that. When interviewed on 5/21/20, at 10:27 a.m. registered nurse (RN)-A stated she was out in the hallway when RA-A came to say that R1 was on the floor. When RN-A got to the rehabilitation room, R1 was lying within the parallel bars, parallel to the bars. R1 had a skin tear on the left elbow and was complaining of pain in his back and right shoulder. R1 was lifted off the floor with a full body lift, assessed, and R1's health care provider was notified. R1 was sent to the

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) emergency room that was attached to the nursing home, via wheelchair, for further assessment. RN-A stated R1's balance waxes and wanes, and he required assistance of two when transferring due to his unsteadiness. RN-A stated she had only worked at the facility a short time, but stated, I know they used to transfer him with one assist but recently he seemed more unsteady so we were using two. He was more shaky and tired, depending on the time of day. During an interview on 5/21/20, at 10:39 a.m. RA-A stated he had been working with R1 for upper and lower extremity strengthening, and in the past five months, R1 had gained strength in his lower extremities, however, RA-A stated his balance and strength still depended on the day, and time of day, and stated R1 always required assist of two staff in the morning with cares due to being more weak and groggy. RA-A stated R1 was always more alert and oriented in the afternoon, so that was the best time to work with him. On the day that R1 fell , RA-A stated it was around 1:00 in the afternoon, and R1 agreed to work with PTA-A. R1's gait belt was put on, and PTA-A and NA-A assisted R1 to ambulate into the hallway, with RA-A following with a wheelchair. R1 walked part way and became tired, so he was pushed by wheelchair into the rehabilitation room. RA-A stated staff from therapy normally worked with R1 alone, and RA-A stated he left the room to assist with another resident. When RA-A walked back by the rehabilitation room, R1 was lying on the floor, and was complaining of pain in his right shoulder and was crying. RA-A indicated he assisted to lift R1 off the floor with the full body lift and transported R1 to the emergency department in his wheelchair. RA-A stated, We always have two staff with transfers. He is that unsteady. If we were to let go, he tends to go back. I assumed that everyone knew that. The main thing is don't let him go backwards .I have worked with him many times in those parallel bars and never had an incident, but I never let go. When interviewed on 5/21/20, at 1:30 p.m. director of nursing (DON) stated R1 had gone back and forth with therapy, would get stronger and do well, and then would become ill and would require physical therapy again. DON stated R1 had made so much progress and was getting stronger, however, We continued to use two assists because his strength is so variable. DON indicated he had no concerns with PTA-A and stated, She's so good. She's so concerned with safety. She just got too comfortable maybe, feeling that he could hold the bars briefly so she could switch positions. During an interview on 5/21/20, at 1:37 p.m. RN-B stated, after a fall with fracture to his left humerus in December, R1 had really gained some strength back, and as of late, was doing well, however, R1's strength had been variable, and required two assist for ambulation and transfers. RN-B indicated R1 had several falls in the past due to self transferring. RN-B stated PTA-A was working with R1, by herself, when the fall occurred. When completing the investigation after the fall, RN-B indicated PTA-A reported R1 had been gaining strength and PTA-A was so confident in his progress that she felt she could let go of him briefly to switch positions. RN-B stated she told PTA-A that the nursing assistants always used two assists for ambulation and transfers. RN-B stated there were never safety concerns when PTA-A worked with residents, and there had never been any prior incidents with PTA-A or therapy in general. When interviewed on 5/21/20, at 6:01 p.m. PTA-B stated she was the clinic manager for Big Stone Therapies, and was PTA-A's manager/supervisor. PTA-B stated a PT is at the facility three days a week and oversees PTA-A. PTA-B stated she received a phone call from PTA-A immediately after R1 fell . PTA-A reported R1 was in the parallel bars, working on some things, and PTA-A was in front of R1. PTA-A was going to move out of R1's way, and the next thing she knew, R1 was on the floor. PTA-B stated she had worked with R1 a few months ago, and stated, He does have a tendency to lose this balance. PTA-B stated, We talked about the situation and what she should have done or could have done differently .having him sit, move wheelchair closer, having someone assist. PTA-B stated, We don't typically have two staff to assist with therapy, and with COVID, we're trying to keep the exposure down. Therapists are treating all patients by themselves. PTA-B stated, My expectation would be, that in the future, to look at the patient that we're treating. During a follow up interview on 5/22/20, at 10:40 a.m. PT stated, When in parallel bars, with (R1's) fall risk and posterior loss of balance, (R1) should have contact guard assist, and stated, Contact guard assist means having your hand on the patient while walking. PT stated, There comes a period of time where less support is needed, based on judgement .I make that judgement by testing it and being right there to catch the patient .We are trying to progress the patient and when we have our hands on them all the time, it gives them a false sense of security. PT stated he and PTA-A discuss patients' status all the time. PT-A stated, I do believe she should have had her hand on (R1). I don't know what lead up to that decision. It's unfortunate, she's very good at what she does. Review of the facility's policy, Using the Care Plan, dated 7/19, included, The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Review of the facility's policy, Falls and Fall Risk-Managing, dated 7/19, included, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.