STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	05/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVERA SUNRISE MANOR	240 WILLOW STREET TYLER, MN 56178

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect for 1 of 3 residents (R2) who had planned interventions for drinking with assisted devices, but were not performed as a result of 1 of 1 staff (nursing assistant (NA)-A) choosing to disregard the care plan, resulting in 2nd [MEDICAL CONDITION] R2. Findings include: Review of the 5/20/20, report filed to the State Agency (SA) identified at 3:15 p.m., R2 was given a cup of hot coffee while in her bed with the head of bed elevate. R2 spilled her coffee affecting the right side of her chest and her right hip. The spilled coffee resulted in a second degree burn to her right hip area. R2 was identified to have severe cognitive impairment with limited range of motion (ROM) in her right upper extremity and required extensive assistance with bed mobility. Review of the 5/25/20, 5-day facility investigation report submitted to the SA identified R2 had requested and received a cup of coffee while in bed with the HOB elevated. She was left unsupervised and had spilled the coffee on her chest and right side which resulted in the hot coffee pooling to right hip and thigh area. The report identified staff did not implement R2's current care plan which indicated R2 required lids on a specialized cup. The care plan further identified the resident was not to receive food or fluids while in bed related to her [DIAGNOSES REDACTED]. The report identified R2's care plan included fluids that were hot were to be covered. The report identified NA-A had been re-educated and understood that the resident should be up in a chair for all meals and snacks. The report further identified that R2 had four areas of redness approximately 6 centimeters (cm) by 2 cm and an area where a blister had popped but the skin remained intact. Review of the facilities 5/20/20, Investigation Documentation, identified R2 had been given a hot cup of coffee in an uncovered Styrofoam cup by nursing assistant (NA-A) while in bed and NA-A then left the room. The investigation documentation identified within minutes NA-A heard yelling and re-entered R2's room. The hot coffee had spilled down the front of R2's clothing and pooled inside her brief on the right hip area. She had sustained a 2nd degree burn to her right hip. R2's 3/14/20, quarterly Minimum Data Set (MDS) identified R2 had severe cognitive impairment and severe decision-making skills. R2 required extensive assistance of two staff for transferring, bed mobility, and toileting. The MDS identified she was independent with set up for eating. R2's [DIAGNOSES REDACTED]. R2's 3/20/20, care plan identified on 9/30/19, R2 was to utilize adaptive equipment related to her decline in activities of daily living (ADLs). She was to have an adaptive cup with handles and lids, a lipped plate, built up silverware, and dycem under her plate to hold in place. This setting was to be placed on a bedside table raised to fit her height. Other interventions that had been in place since 7/31/19, included liquids were to be covered. If liquids were too hot, water was to be added. R2 was not to have food or liquids while in bed. R2 had a history of [REDACTED]. Review of R2's undated nursing assistant (NA) care sheet identified R2 was to have cups with handles. R2 was not to eat in bed and had to be in her wheelchair (WC) in an upright position for all meals. Observation on 5/26/20 at 9:24 a.m., identified R2 shared a room with another female resident. R2 was observed in her WC watching television seated in front of a bed table with two Styrofoam cups with lids and straws. R2's room was located at the end of a hallway and when observed staff were not present. Additional observation at 12:00 p.m., R2 was eating lunch in the dining room with a two handled covered adaptable cup with hot tea and built up silverware with a divided plate to assist her to eat independently. Interview on 5/26/20 at 10:00 a.m., with NA-C identified at meal time room trays are distributed by NA's. Staff were to have the resident out of bed and in a chair or their WC with a table in front of them. The NA's will then call down to the kitchen to set up the meal trays for staff to deliver to resident room. NA-C identified our process is to get four people up and served at a time. NA-C identified if there is an incident or accident they are to stay with the person and call for help. The nurse would be called into the room to assess the resident. Nursing is responsible for completing a report and contacting the doctor and family. Interview on 5/26/20 at 10:40 a.m., with registered nurse (RN)-A identified to be the charge nurse on the afternoon of 5/20/20. She had been called into R2's room around 3:00 p.m., found R2 in bed with HOB elevated and her top was wet from spilled coffee. RN-A identified R2's top was removed and the skin assessed. R2's skin on the upper half of body was intact with no redness or signs of trauma. At the time of the skin assessment staff had went to change R2's brief and a burn to the right hip and thigh area was identified. The hot liquid had pooled in the brief causing reddened areas and a blister. The blister was intact at that time and the area was left open to air. R2 was then kept off of her right side to avoid pressure to the area. RN-A identified she had been called into the room within minutes of the incident. RN-A identified NA-A reported R2 requested to stay in bed for her coffee and snacks. NA-A had elevated R2's head of bed and gave her a cup of coffee in a Styrofoam cup that did not contain a lid. NA-A left the room to finish passing snack cart and within 5 minutes heard the call for help. NA-A communicated to RN-A she had went back into room and discovered the spilled coffee. The physician was contacted as well as R2's son. RN-A identified R2 does have periods of forgetfulness, but was able to identify she had spilled the coffee on herself. Interview on 5/26/20 at 10:58 a.m., with dietary manager (DM)-D identified the care plan will list adaptive equipment for the resident. If there is not a care plan for adaptive equipment then the resident would receive liquids in a heavy weight disposable cup with a lid. The snack cart is set up by dietary and will have the adaptive equipment placed on the cart. The cart will also have the heavy weight disposable cups for those residents who do not require adaptive equipment. The NA assigned to pass the snack cart is responsible for knowing the care plan and what adaptive equipment a resident is to use. The DM-D identified she was not aware of the incident until she read the progress notes and then spoke to the charge nurse. Observation on 5/26/20 at 12:17 p.m., with NA-B and NA-C of R2's right hip and thigh area revealed an open area approximately the size of a 50 cent piece where a blister had opened. A scant amount of yellow drainage had been noted on her brief. Approximately 1 to 2 inches below that area were 2 small intact reddened areas. Interview on 5/26/20 at 2:06 p.m., with NA-A identified on 5/20/20, she had passed snack chart that afternoon. R2 was still in bed at snack time and requested her snack and hot beverage while in bed. NA-A identified she elevated head of bed, then gave her a hot beverage in a Styrofoam cup with no lid. NA-A then left the room to go to the next room and within minutes heard R2's roommate yell for assistance. NA re-entered room to discover R2's shirt was wet. She then got a towel that was in the room and placed it between the wet shirt and resident's skin. She then identified she left the room to get the charge nurse to come and assess her. No redness was noted on the upper part of R2's body but when they went to change the bedding the redness of the hip was discovered. NA-A identified the area was just really red and at that time there were no blisters or bubbles. NA-A identified there had not been an adaptive cup on the snack cart that day. NA-A confirmed instead of taking the time to go back into the kitchen to get the adaptive cup she used what was available on the cart, disregarding R2's care plan. Interview on 5/26/20 at 2:21 p.m., with administrative assistant (AA)-B identified it was her responsibility to update the NA care sheets. AA-B identified R2's care plan had been updated on 5/20/20. AA-B identified R2 is not new to the facility and prior to the 5/20/20 update the care plan had identified R2 was to have an adaptive cup with handles and lid. The care plan also had identified R2 needed to be out of bed related to history of spilling food. The expectation would be staff caring for the resident needed to know what is on care plan. NA's are to be carrying care sheets with them and be able to pull out of their pocket to review when in question. Interview on 5/26/20 at 4:00 p.m., with

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

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) director of nursing (DON) who identified at the beginning of each shift NA's are expected to obtain a care plan sheet for the area they are working. Her expectation for staff would have been to have read and understood care plan. She would expect staff to make sure they have the adaptive equipment needed for the resident and if not, residents were not to be given substitutes that may cause harm. The DON identified NA-A had been verbally counseled after incident on 5/20/20 by charge nurse. She also followed up with NA-A that day and provided some feedback on the same information the charge nurse had provided to her. DON identified that NA-A understood the policy and procedures. DON identified that everyday at 2:00 p.m. we have a conversation with the day and afternoon shift to follow up on any changes and incidents that may have happened. DON identified she will be having staff training on 5/27/20 to re-educate all staff. She was unable to provide written documentation on the re-education provided to NA-A. Interview on 5/26/20 at 4:15 p.m., with Administrator identified he was aware of the incident and did not have any addition information to add. Review of the 9/2019, Vulnerable Adult Abuse Prevention Plan, identified the residents have a right to be free from neglect. Neglect was defined as a failure of the facility and it's employee's to provide services that are necessary to avoid physical harm.