STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	**06/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEILSON PLACE	**1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601**

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 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, and provide ongoing treatment including medical attention for 1 of 3 residents reviewed who had sustained a significant skin injury following a fall. This failure resulted in actual harm due to identification of the wound requiring sutures which could not be applied due to the delayed identification of the significance of the wound. Findings include: R3's undated face sheet indicated R3's [DIAGNOSES REDACTED]. R3's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R3 had moderate cognitive impairment and was independent with all activities of daily living (ADLs) with setup help from staff. The MDS indicated R3's skin was intact. R3's care plan dated 4/5/19, identified a self care deficit and directed the staff to supervise R3 with dressing and one staff to physically assist with bathing, pivot transfers, and ambulation with a wheeled walker. The care plan also indicated R3 had no skin issues. R3's Progress Note (PN) dated 6/5/20, at 4:01 a.m. indicated a V shaped skin tear was noted on R3's right elbow that measured 1.5 centimeters (cm). R3 stated he had fallen down onto the toilet hitting his elbow on the bar. The area was cleansed and covered with a 2 X 2 gauze and transparent dressing. However, R3's treatment record lacked information related to the skin injury and need for follow up/treatment. On 6/11/20, at 3:00 p.m. R3 was observed in his room, seated in the wheelchair with his right arm bent and resting on his lap. R3 lifted his right arm up with his left hand and stated he was not doing so good. It's my arm, I fell in the bathroom and hit it on the rail in there. R3 stated he wanted to go to the doctor, but the staff had taped it up, bandaged and wrapped his arm. R3 added, I think I need stitches. R3 stated the injury occurred about a week ago and verified that he did not ask for help with mobility into the bathroom because, I just go myself. If you are from the department of health, maybe you can look into it. On 6/12/20, at 8:15 a.m. R3 was observed seated in the wheelchair, in his bathroom facing the sink. -At 8:31 a.m. R3 was observed seated on his bathroom toilet. No staff entered the room. -At 8:35 a.m. staff entered the room and reminded R3 of the need to call for assistance in order to prevent falls. R3 refused assistance and remained sitting on the toilet. Staff exited the room. -At 8:37 a.m. staff entered R3's room and assisted him to finish toileting. -At 9:30 a.m. R3 stated, My elbow hurts, would you like to see it? and proceeded to remove the Kerlix wrap which was covering his right elbow wound. The wound appeared to have an open area that was approximately 2.0 cm in length and when R3 lifted up his elbow, the wound gaped open approximately 1.0 cm with an observable, undetermined depth. R3 stated he had asked the nurse for a new dressing, but she said he was not on her list of dressing changes to be completed that day. -At 9:35 a.m. the surveyor (SA) requested that RN-A notify the SA when she performed R3's right elbow dressing change so that the SA could observe it. -At 9:37 RN-B approached the SA and stated R3 did not have a dressing change ordered. When RN-B was informed R3 had an open area on his right elbow, RN-B stated there was no documented evidence of a dressing change order for R3's wound on the medication or treatment record. RN-B stated typically if a resident had an open area/wound, it would be identified on the treatment record and would include treatment orders. At this time, RN-B stated she was going to go look at R3's wound. Upon nearing R3's room, RN-A was observed exiting R3's room and stated to RN-B, yeah it is bad, it should have had stitches. I don't work here that often, so I was not aware of it. RN-A stated it was too late to send R3 into the clinic for stitches, therefore, RN-B directed RN-A to apply Steri-strips to the wound and to notify the physician for further orders. -At 9:44 a.m. a telemed visit was conducted with R3's primary physician who prescribed treatment orders, a wound program, and a follow up evaluation to be done in one week. R3's Physician Office Visit Note dated 6/12/20, indicated R3 had been evaluated for a skin tear on his right elbow following a fall in 6/5/20, and staff were wondering if the wound needed to be pulled together, but a week had past. The note indicated R3's elbow appeared to have a 2.0 cm length by a 0.5 cm width, triangular shaped skin tear directly over the olecranon prominence of the right elbow. The skin edges are withdrawn about a 1.0 to 1.5 cm and 0.5 cm depth at the worst midpoint of the triangle. There is no drainage. At this late juncture it is not worth placing sutures rather a Q-tip was to be used to lift the skin edge to try to approximate the tear a little better then to secure and place Steri-strips in an attempt to bring the wound edges together a little. Antibiotic ointment and a [MEDICATION NAME] (a transparent dressing) to be applied for one week at which time the physician would discuss proper removal of the [MEDICATION NAME] and replacement with the facility. On 6/12/20, at 1:30 p.m. a telephone interview was attempted with R3's unit manager, without success. On 6/12/20, at 3:30 p.m. during a telephone interview, the director of nursing (DON) stated she had only been in her position for four weeks, but had been aware of R3's right elbow skin wound as a result of a fall on 6/5/20. The DON stated the interdisciplinary team (IDT) had discussed the incident the next day and was told R3 had denied falling and would not allow staff to look at his arm. The DON stated she, herself had not visualized the wound as she had been told R3 would not allow the wound to be looked at. The DON acknowledged R3's documentation indicated the nurse had assessed and treated the skin injury as soon as it was identified, but had not noted the wound or treatment provided onto R3's treatment record in order to alert the staff that he had the wound and the need to continue monitoring it. In addition, the DON stated she would have expected there to have been more documentation related to R3's wound in his clinical record. The facility's Skin Risk Assessment Interventions policy revised on 4/25/19, indicated if a resident had a pressure injury or skin breakdown to complete the treatment as ordered, monitor area daily, conduct a weekly comprehensive assessment, document, and to monitor the wound for signs of infection.
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 interview and document review, the facility failed to comprehensively assess and/or develop and implement fall interventions in order to minimize the risk for falls and injury for 2 of 3 residents (R1, R3) identified at risk for falls. This failure resulted in actual harm when R1 was not provided timely toileting assistance and her wheelchair had not been positioned by the bed, as directed, resulting in a fall and subsequent sacral fracture. This failure also resulted in actual harm when R3 did not receive comprehensive assessments and implementations of new fall interventions following each falls per the facility fall policy resulting in a significant skin injury which would have required the application of sutures. Findings include: R1's admission Minimum Data Set ((MDS) dated [DATE], indicated R1's [DIAGNOSES REDACTED]. The MDS also indicated R1 required limited assistance with transfers, dressing, and personal hygiene and extensive assistance with bed mobility and toileting. R1 had not ambulated and required assistance with mobility in her wheelchair. R1 had a history of [REDACTED]. R1's Activities of Daily Living (ADL) Functional Status Care Area Assessment (CAA) dated 5/26/20, indicated R1 had fallen at home and sustained a left [MEDICAL CONDITION] with surgical repair. R1's nurses noted reflected

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) forgetfulness and confusion at times and indicated R1 required ADL assistance. R1's Fall CAA dated 5/26/20, indicated R1 was at risk for falls related to her history of falls, medications, slight cognitive impairment, incontinence and pain. The undated, personal care sheet, a pocket care plan utilized by the nursing assistant's, indicated R1 had a left [MEDICAL CONDITION] with surgical repair and was partial weight bearing to left leg, had bouts of confusion, was at risk for falls, and directed the staff to provide every 30 minutes rounding checks, assist of one to transfer with a walker and gait belt, a low bed, pendant call light, hip protectors to be worn, wheelchair to be at bedside, signage in room to remind to call for assistance, and to toilet every two hours and at 4:00 a.m. and 6:00 a.m. R1's comprehensive care plan created 5/26/20, indicated R1 had mild cognitive impairment, had a potential for falls due to a history of falls, medication use, limited mobility, incontinence, and cognitive deficit. The care plan directed the staff to keep assistive devices and call light within reach, hip protectors on when awake, 30 minute rounding (visual checks), frequent reminders to use call light, signage for reminders to call for assistance, offer toileting every two hours and at 4:00 a.m. and 6:00 a.m., assist of one with a front wheeled walker and gait belt for transfers, low bed, bed to be at transfer height for all transfers, pendant call light, and to initiate and reinforce safety teaching. The care plan also indicated R1 was at risk for potential complications related to anticoagulant (blood thinner) therapy and directed the staff to protect R1 from injury/trauma. R1's Fall Risk Assessment, dated 6/2/20, identified R1 was at risk for falls. R1's clinical record lacked any previous fall risk assessments. R1's 5/30/20, incident report submitted to the State Agency (SA) indicated on 5/30/20, R1 was found on the floor, in her room. R1 stated she was trying to ambulate to the bathroom when she fell . R1's Nurse Progress Note (PN) dated 5/28/20, indicated R1 was alert and orientated with confusion at times. She was able to use the call light appropriately most times, was continent of bowel and bladder, and required assistance of one with ADL's and to pivot transfer. R1's PN dated 5/29/20, indicated R1 required extensive assistance of one for wheelchair locomotion on the unit. R1's PN dated 5/30/20, at 12:06 a.m. indicated staff had heard R1 yelling for help. R1 was found seated on the floor, in her room. Staff assessed R1 and with the assistance of three staff and a gait belt, assisted R1 up off the floor. Upon rising, R1 immediately complained of pain in her left and was assisted to sit in her wheelchair then pivot transferred to her bed. Upon transfer, R1 again complained of increased pain in her left leg. Staff assessed R1's left hip area and noted deformity to the upper left leg and swelling. The on call provider was contacted. R1's PN dated 5/30/20, at 12:42 a.m. indicated an ambulance was called to transfer R1 to the emergency room . A subsequent PN at 3:51 a.m. indicated the emergency room staff called and notified the facility that R1 had re-fractured her left hip and world be admitted to the hospital for further care. R1's 6/5/20, 5 day investigation report submitted to the SA indicated R1 had sustained a fall with significant injury due to staff not following R1's care plan, as directed. The report indicated the care plan directed the staff to keep R1's wheelchair at bedside and to toilet R1 every two hours. The investigation revealed R1's wheelchair was not positioned at her bedside rather was positioned across the room, and R1 had not been toileted every two hours as directed. The facility re-educated the staff on the importance of following care plan directives and were directed to review the personal care attendant (PCA) sheets (pocket care plans which identified each resident care needs) at the start of every shift. The report also indicated R1 had not sustained a hip re-fracture, but did sustained a sacral fracture as a result of the fall. On 6/12/20, at 3:30 p.m. the director of nursing (DON) stated R1's care plan indicated a fall prevention program was in place which would refer the reader to the PCA for the individualized interventions implemented. The DON stated during the investigation of R1's fall, it was discovered that the staff did not follow R1's care plan regarding placing the wheelchair by the bed and toileting R1 every two hours as R1 had not been assisted with toileting since 8:00 p.m. the previous evening (approximately four hours prior to the fall). R3's undated face sheet indicated R3's [DIAGNOSES REDACTED]. The MDS also indicated R3 was occasionally incontinent of bowel and bladder and had experienced two or more falls since his last assessment. R3's care plan dated 4/5/19, identified a self care deficit and directed the staff to supervise R3 with dressing and one staff to physically assist with bathing, pivot transfers, and ambulation with a wheeled walker. The care plan indicated R3 often transferred himself and did not ask for help. The care plan also indicated R3 had occasional incontinence and directed the staff to offer toileting every two hours when awake to help avoid self transfers. The care plan indicated R3 was at risk for falls and directed the staff to place R3 on a fall prevention plan, provide a walker, encourage R3 to sit while praying, to not give R3 powder, to encourage use of gripper socks at all times, encourage to call staff for assist, conduct frequent and purposeful rounding, offer and assist as he would allow with showers, provide a longer phone cord and a one way glide and anti roll back on wheelchair. Review of R3's PN revealed the following: -On 2/21/20, at 3:20 a.m. R3 was found sitting on the bathroom floor. His brief and pants were lying on the floor next to him with the wheelchair nearby with the brakes engaged. No injuries were noted. R3's clinical record lacked evidence of a root cause analysis and interventions implemented. -On 3/15/20, at 6:31 a.m. R3 was found on the shower floor. He stated he purposely got down on the floor and was wiping up excess water but could not get himself back up. R3's clinical record lacked evidence of a root cause analysis and interventions implemented to prevent future occurrences. The record also indicated R3 would independently take a shower in his bathroom shower. -On 3/29/20, R3 rang his call light and was found sitting on the bathroom floor. R3 stated he had lost his footing on the slippery bathroom floor and went down, landing on his buttocks. R3 had had a bowel movement which was noted on the floor, R3's shoes, and on the toilet seat and bowl. R3's clinical record lacked evidence of a root cause analysis and interventions implemented. -On 4/1/20, at 9:17 a.m. indicated R3's care plan was reviewed. A subsequent note dated 4/2/20, at 9:02 a.m. indicated care plan review directed staff to increase scheduled toileting, to offer toileting every two hours while awake with a goal of one or less incontinent voids per week. However, the note did not identify the effectiveness of the current fall interventions nor any new fall interventions implemented. -On 6/5/20, at 4:01 a.m. a V shaped skin tear was noted on R3's right elbow that measured 1.5 centimeters (cm). R3 stated he had fallen down onto the toilet hitting his elbow on the bar. The area was cleansed and covered with a 2 X 2 gauze and transparent dressing. An incident report was completed, however, did not include a root cause analysis or evaluation of the bathroom to ascertain how R3 obtained the injury. -On 6/12/20, at 9:50 a.m. staff entered R3's room to assist R3 as he had transferred himself to the toilet. R3 was very resistive with staff. R3 was reminded to use call light to ask for assistance. R3 stated he did not need help. R3 was reminded of his previous falls and was asked to use his call light in order to prevent future falls. Writer indicated this conversation with R3 would be discussed with the nurse manager on her return. R3's clinical record lacked evidence of a comprehensive assessment of the aforementioned fall incidents which would have included a root cause analysis. The record also lacked an assessment on how R3 sustained a skin tear on his right elbow from the toilet grab bars following a fall. On 6/11/20, at 3:00 p.m. R3 was observed in his room, seated in the wheelchair with his right arm bent and resting on his lap. R3 lifted his right arm up with his left hand and stated he was not doing so good. It's my arm, I fell in the bathroom and hit it on the rail in there.At this time, two U-shaped metal bars were observed bolted to floor on both sides of the toilet. The bars had a smooth surface with no sharp edges noted. R3 stated he wanted to go to the doctor, but the staff had taped it up, bandaged and wrapped his arm. R3 added, I think I need stitches. R3 stated the injury occurred about a week ago and verified that he did not ask for help with mobility into the bathroom because, I just go myself. If you are from the department of health, maybe you can look into it. On 6/12/20, at 8:15 a.m. R3 was observed seated in the wheelchair, in his bathroom facing the sink. -At 8:31 a.m. R3 was observed seated on his bathroom toilet. No staff have entered the room. -At 8:35 a.m. staff entered the room and reminded R3 of the need to call for assistance in order to prevent falls. R3 refused assistance and remained sitting on the toilet. Staff exited the room. -At 8:37 a.m. staff entered R3's room and assisted him to finish toileting. -At 9:30 a.m. R3 stated, My elbow hurts, would you like to see it? and proceeded to remove the Kerlix wrap which was covering his right elbow wound. The wound appeared to have an open area that was approximately 2.0 cm in length and when R3 lifted up his elbow, the wound gaped open approximately 1.0 cm with an observable, undetermined depth. R3 stated he had asked the nurse for a new dressing, but she said he was not on her list of dressing changes to complete that day. -At 9:35 a.m. the SA requested that RN-A notify the SA when she performed R3's right elbow dressing change so that the SA could observe it. -At 9:37 RN-B approached the SA and stated R3 did not have a dressing change ordered. When RN-B was informed R3 had an open area on his right elbow, RN-B stated there was no documented evidence of a dressing change order for R3's wound on the medication or treatment record. RN-B stated typically if a resident had an open area/wound, it would be identified on the treatment record and include dressing change orders. At this time, RN-B stated she was going to go look at R3's wound, however, upon nearing R3's room, RN-A was observed exiting R3's room and stated to RN-B yeah it is bad, it should have had stitches. I don't work here that often, so I was not aware of it. RN-A stated it was too late to send R3 into the clinic for stitches therefore RN-B directed RN-A to apply Steri strips to the wound and notify the physician for further orders. -At 9:44 a.m. a telemed visit was conducted with R3's primary physician who described and prescribed orders for a

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) wound program, with a follow up evaluation to be done in one week. R3's Physician Office Visit note dated 6/12/20, indicated R3 had been evaluated for a skin tear on his right elbow following a fall in 6/5/20, and staff were wondering if the wound needed to be pulled together, but noted a week had already past. The note indicated R3's elbow appeared to have a 2.0 cm by 0.5 cm triangular shaped skin tear directly over the olecranon prominence. The skin edges are withdrawn about a 1.0 cm to 1.5 cm and 0.5 cm depth at the worst midpoint of the triangle. There is no drainage. At this late juncture, it is not worth placing sutures and directed the staff to use a Q-tip to lift the skin edge to try to approximate the tear a little better then to secure and place Steri-strips in an attempt to bring the wound edges together a little. Antibiotic ointment and a [MEDICATION NAME] (a transparent dressing) to be applied for one week at which time the physician would discuss proper removal of the [MEDICATION NAME] and replacement with the facility. On 6/12/20, at 1:00 p.m. RN-B stated she was not aware that the facility's fall policy directed RN or physical therapist (PT) to observe a resident transfer following each fall and confirmed this evaluation had not been completed. RN-B verified the staff were not completing fall risk assessments and developing and implementing new interventions after each fall, rather would complete a fall risk assessment only if something had changed with the resident. In addition, RN-B stated she would have expected the nurse to have assessed the bathroom to investigate how R3 had cut his elbow on the toilet grab bar and document that assessment in R3's PN's. RN-B stated there would have been plenty of other interventions to implement in an attempt to minimize falls and/or injury. On 6/12/20, at 1:30 p.m. a telephone interview was attempted with R3's unit manager, without success. On 6/12/20, at 1:38 p.m. occupational therapist (OT)-A stated the head therapist attended the facility's interdisciplinary meetings meetings (IDT), but she did not think on a daily basis. OT-A stated the occupational therapy department would receive referrals for evaluations following a resident's fall and verified a referral had not been received following R3's falls. On 6/12/20, at 3:30 p.m. during a telephone interview, the director of nursing (DON) stated she had only been in her position for four weeks therefore was not familiar with R3's March 2020, falls. However, the DON stated she had been aware of R3's right elbow skin tear wound as a result of landing on the toilet hard on 6/5/20. The DON stated the IDT had discussed the incident the next day and was told R3 had denied falling and would not allow staff to look at his arm. The DON verified R3's falls had not been comprehensively assessed which would have included the identification and potential elimination of the cause of the elbow injury, and a RN or physical therapist evaluation of R3's transfer abilities in order to identify a need for therapy and/or new interventions to be implemented. The DON stated the IDT as well as nursing staff should have attempted to identify and implement alternative interventions for safe transferring techniques for R3. The facility's Fall Management Program policy and procedure revised 12/10/18, indicated after each fall, staff were to implement immediate interventions to prevent another fall and identify possible or likely causes. Staff were to evaluate the chain of events or circumstances preceding a fall and continue to collect and evaluate information until they either identified the root cause of the fall, or determined the cause could not be found. The policy also directed the staff to complete a post fall evaluation which consisted of a nurse or physical therapist observation of the resident transferring and if had difficulty transferring, an additional evaluation may be initiated. The policy directed the staff to ensure the post fall assessment and interventions implemented were documented.