STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MN VETERANS HOME - LUVERNE	1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156

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 -** Immediate jeopardy **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 interview and document review, the facility failed to provide appropriate care and services including assessment, monitoring and intervention for 1 of 1 resident (R9) with a fall with severe head injury. R9 experienced changes in physical and mental condition but treatment was delayed. This resulted in an Immediate Jeopardy (IJ) situation for R9 who experienced increased pain and subsequent death. The IJ began on [DATE], when R9 experienced a fall with head injury and the facility failed to appropriately assess, monitor and intervene resulting in R9's death. The administrator and director of nursing (DON) were notified of the IJ on [DATE] at 2:30 p.m. The IJ was removed on [DATE] at 12:30 p.m., when it could be verified by interview and document review, the facility had taken steps to remove the immediacy however, non-compliance remained at the scope and severity of G, isolated-actual harm that is not immediate jeopardy. Findings include: R9's quarterly Minimum Data Set ((MDS) dated [DATE], identified R9 had moderate cognitive impairment. R9 required extensive assistance of 1 staff person for bed mobility, transfers, locomotion on the unit, dressing, toileting, and personal hygiene. Limited assistance with a walker for ambulation in room and hall. The [DATE], Care Area Assessment (CAA) identified R9 was at risk for falls due to balance problems and unsteadiness when moving from a sit to stand position. The residents MDS indicated R9's [DIAGNOSES REDACTED]. R9's [DATE], care plan identified he had impaired mobility due to history of a stroke. He was able to ambulate short distances with assist of one staff, a walker, and gait belt. The care plan also indicated R9 was at risk for falls and was utilizing a blood thinning medication, [MEDICATION NAME]. Review of facility report to the State Agency (SA) dated [DATE], identified on [DATE] at 6:25 a.m., nursing assistant (NA)-A was assisting R9 to the toilet when she left him unattended to open the bathroom door. R9 was utilizing his walker, took a couple of steps, and fell backwards from a standing position, striking his head against the floor with a loud crack sound. Registered nurse (RN)-A was summoned to the room, assessed R9 and noted a large lump located at the base of R9's skull. Vital signs (VS) and neurological status were documented as stable at that time. R9 was not able to state to staff what had happened, but remarked that hurt. R9 was transferred into bed using a sling lift. At approximately 7:00 a.m., that same day, R9 complained of new onset headache and low back pain. Staff administered Tylenol and an ice pack to R9 for comfort. There was no mention staff had assessed the size or description of the lump located at the base of R9's skull or appropriately notified the provider of the severity of the fall. Review R9's [DATE], nursing progress and incident notes included: 1) 6:25 a.m., NA-A was assisting R9 to toilet. NA-A stepped around and in front of R9 to open the closed bathroom door. NA-A and NA-B (who was assisting R9's roommate) were not close enough to intervene when R9 fell to the floor. NA-A went to summon RN-A to the room as NA-B remained with R9. RN-A performed an assessment, noted a lump on the back of R9's head. R9 denied pain and was not able to state what had happened, only that it hurt. R9 was able to move all extremities and was transferred into bed with the use of a sling lift and assistance of the 2 NAs and the RN. VS were reported as normal at that time. There was no mention staff had immediately called R9's provider or EMS at that time. 2) 7:00 a.m., R9 complained of a headache and would not speak with NA-B. RN-A administered Tylenol and provided an ice pack for the back of R9's head. 3) 7:16 a.m., R9 complained of lower back pain. Staff elevated R9's head of bed. R9 was given an ice pack to back of his head. R9 was observed rubbing the top of his head. R9 followed commands of squeezing hands. R9 displayed facial grimacing when his hip area was touched. 4) 7:24 a.m. RN-A sent a faxed notification to the provider of R9's fall. 5) 7:47 a.m., staff documented R9 was ambulating with walker at the time of his fall, lost his balance falling backwards hitting his head. Staff had to open R9's bathroom door and were not immediately at his side when the incident occurred. A lump was immediately noted at the base of his skull. R9 initially denied pain, then complained of head and back pain 30 minutes later. 6) 8:24 a.m., family was called and updated on the fall and pain in back and neck. VS and neurological signs were noted to be within normal limits at that time. 7) 9:24 a.m., staff administered 650 milligrams (mg) Tylenol for pain and noted it was effective. 8) 9:40 a.m., during assessment, R9 was observed as Sleepy. Does not wake enough for the neuros (neurological checks). Resident does not follow commands of squeeze this writer's hands. R9's VS at that time were blood pressure (BP) ,[DATE] millimeters of mercury (mm/hg), pulse (P) was 113 beats per minute (normal ,[DATE]), Oxygen saturation (SpO2) was 92% (normal ,[DATE]), and temperature was 96.9 degrees Fahrenheit (F). R9 appeared comfortable. There was no indication staff reached out to the resident's medical provider. 9) 10:09 a.m., R9's family was called to update on R9's condition since his fall. Staff noted they discussed possible signs and symptoms of a head injury from the fall. Family was made aware of the possibility will give Tylenol TID (three times per day) for 7 days. 10) 12:05 p.m., R9 was noted to open his eyes for a short period of time, then close. R9 could not follow simple commands. Staff then documented they made measurements of the raised bruise on back of his head measuring 5 centimeters (cm) in circumference. Staff noted they would monitor that area until healed. An ice pack was applied to the area 2 times that shift. R9's respirations increased to ,[DATE] respirations per minute (normal ,[DATE]). R9's family was called and updated. Family reportedly wished for R9 to be kept comfortable and would come to the facility around 1:00 p.m. to decide how to proceed with care. There was no mention on what R9's family had been updated on. There was no indication R9's medical provider was updated. 11) 12:20 p.m., R9 was attempting to throw his legs out of his bed. R9 was then assisted to sit up on edge of bed and into his wheelchair. R9 was given Tylenol again, and ate some cereal. Shortly after eating, R9 began gagging and spitting up. R9's SpO2 decreased to 70% and had upper airway gurgle. Family was again called and updated and requested he be sent to ER. There was no mention staff had assessed R9's throat to identify what was causing the gurgle, why R9 was gagging or spitting up. There was no indication R9's medical provider was updated, nor that EMS had been contacted immediately for transport. 12) 1:24 p.m., a call placed to the ER and an ambulance paged. There was no documented indication as to they delay in accessing EMS. 13) 1:48 p.m., EMS arrived to transport R9 to the ER. 14) 3:15 p.m., a call was received from the ER, R9 had been admitted for comfort cares. R9's CT scan showed a significant brain bleed. Family was at his bedside. R9 was unresponsive at that time. 15) 4:08 p.m., documentation identified R9 had a change in mentation and family had been notified earlier that day at at 10:10 a.m Family opted to have staff watch R9 at that time. R9 became restless, sat up, ate, and had vomited and was declining from his baseline. R9 was sent to ER per family request and had been admitted for comfort cares with a brain bleed. 16) 4:47 p.m., a call was received from the hospital notifying staff R9 would be returning to facility on comfort cares. Family was agreeable and a potential hospice consult was ordered for the following day. 17) R9 returned to the facility around 6:00 p.m. 18) 7:30 p.m., R9 was noted as resting quietly with family at his bedside. R9 required oxygen and remained unresponsive, breathing more labored. 19) 9:00 p.m., R9 passed away. Review of the [DATE], physician (MD)-B progress note of the events surrounding R9's fall identified R9 was used a walker with a nurse aid (NA) and nurse to the toilet. They were assisting him. R9 usually walked with the walker just fine. He showed no identified health concerns at that time. R9 had requested to use the toilet. Staff got R9 up and walking toward the bathroom. 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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) bathroom door had been closed. As the NA reached to open the door, R9 spoke out quickly and fell directly back onto his head and back. According to MD-B, R9 was monitored throughout the next couple hours by the nursing staff and had continued decline in his mental status and also his breathing status. Staff reported they had consulted with family and at first, family had not wanted him evaluated, but staff later sent R9 to the ER. At that time, R9 was noted that he had a pneumonia. During his ER evaluation he continued to have troubles with breathing. It was decided to do comfort measures while he was undergoing CT scan (medical imaging procedure). The CT of his head showed mixed subdural hematoma (brain bleed). Also, a large amount of subarachnoid hemorrhage (life-threatening condition caused by bleeding in brain). R9 had hemorrhagic contusions (bleeds from trauma). In addition R9 had a large posterior (back of head) scalp hematoma (blood pooling under surface of skin) with an underlying occipital bone (back of head) fracture extending into the base of his skull. R9's cause of death was the brain bleeds, however MD-B felt R9 had an underlying issue of the pneumonia was his cause for the fall. Primarily the cause of the fall was the pneumonia, and hemorrhage and skull fracture are secondary to the pneumonia. Review of the [DATE], hospital radiology report identified R9 had a [DIAGNOSES REDACTED]. The findings were discussed with family by the ED medical provider and the decision was made to keep R9 comfortable. Interview on [DATE] at 9:51 a.m., with the assistant director of nursing (ADON), identified NA-A was assisting R9 with toileting and stepped away from R9 to open the bathroom door. As NA-A turned she observed R9 lose his balance, falling backwards, striking his head on the floor. NA-A was not close enough to assist R9 to potentially decrease the severity of his fall. R9 was noted to have a large hematoma (area of blood pooled under skin) on the back of his head immediately after the fall. RN-A responded to R9's room and completed vital signs and a neurological assessment which had been documented as normal. The fall was reported as having occurred during morning cares between 6:00 and 7:00 a.m RN-A had faxed notification of the fall to the provider at 7:24 a.m. R9's change in condition occurred with a change in mentation documented at 10:00 a.m. Family member (FM)-A was initially contacted and notified of the fall at 8:24 a.m. by RN-B, and again following the 10:00 a.m. assessment. FM-A was updated of R9 being drowsy and not wanting to get out of bed. FM-A voiced agreement for the facility to continue to observe R9. If he still had not wanted to get up by around 12:00 noon, the family advised staff they would come to the facility to see if they could convince him to get up. Between 11:00 a.m. and 12:00 noon R9 became restless, and was assisted into his wheelchair. He was offered hot cereal and coffee by staff and following eating, began gagging. He declined in mental status and his VS were abnormal His SpO2 was 70%. R9 was administered supplemental oxygen. FM-A was contacted around 12:30 p.m. with an update and requested R9 be sent to the ER. RN-A had informed the MD via fax following the incident at 7:24 a.m., however, the facility did not maintain documentation of the fax being sent, nor did the facility receive conformation the fax had been received or reviewed by the provider. There was no additional documentation of the medical provider being updated on R9's condition until about 1:34 p.m. along with notification of the ambulance prior to his transfer to the ED. Staff had not called EMS when the incident occurred or placed a call to R9's physician. Interview on [DATE] at 2:06 p.m., with NA-B identified she was present in R9's room the morning of his fall and had been providing care for his room mate. NA-B observed R9's fall. NA-B observed NA-A assist R9 to sit on the side of the bed, place his walker in front of him, pull back his privacy curtain, and walked over to bathroom door and held door open for R9. R9 stood up independently without NA-A's assistance, took about 3 steps, and fell straight back holding his walker. NA-B reported R9 fell like a tree. He fell straight back, first striking his shoulders, then his head., making a loud, cracking sound. NA-B was unable to reach him in time to prevent his fall. Immediately after the fall, R9's eyes were open but he failed to respond to verbal prompts. R9 was transferred by staff into bed using a total body lift. RN-A completed the initial assessment for injury. RN-A left to complete a fall risk assessment, and NA-A left to continue providing cares to other residents. NA-B remained at R9's bedside as she was not comfortable leaving him alone. R9 had a soft ball sized swelling at the base of his skull. RN-A returned with an ice pack and placed it on the back of R9's head. At the time of injury R9 denied pain, but after a short time he complained of pain in his head. NA-B had reported R9 was having pain and due to his hitting his head so hard, questioned RN-A if he was going to be sent to the ER. RN-A responded he wasn't going to be sent to the ER as he would just be sent back. Staff could watch him in the facility. There was an immediate change in R9's status as he would usually answer her questions and carry on a conversation. Following the fall, R9 would only respond with one word answers and closed his eyes and kept them closed even when responding to a question. R9 would open his eyes periodically when asked to, but closed them again right away. Interview on [DATE] at 2:34 p.m., with NA-A identified she was providing morning cares for R9 and was assisting him to the toilet. NA-A identified the bathroom door was closed so she stepped ahead of R9, leaving him unassisted, to open the door. She had not been utilizing a gait belt or provide extensive assistance as was identified in the care plan. When NA-A turned after opening the door, she observed R9 fall backward from a standing position striking his head against the floor. R9's fall happened so quickly she did not have time to intervene. R9 was holding his walker and fell backward without attempt to break his fall. RN-A assessed R9, but he was not able to describe what had happened and stated, that hurt. R9 was transferred into bed with the use of a total body lift with staff assist of three. R9 had denied pain when placed in bed. Interview on [DATE] at 8:45 a.m., with FM-A identified R9's family was concerned about his death and she discussed the incident with the head nurse (DON). FM-A had been telephoned by RN-B between 8:00 a.m. to 8:30 a.m. on [DATE], and informed R9 had taken a hard fall and was doing ok. FM-A was told R9 complained of lower back pain and staff were watching his VS which were reported to be elevated. R9 had received Tylenol and was advised by RN-B, elevated vital signs often corresponded with pain. FM-A identified she was ok with the limited information regarding R9's condition at the time. FM-A requested RN-B keep her updated. FM-A later received a call from RN-B at approximately 10:30 a.m. with the update R9 was still resting with no changes, but was drowsy and didn't want to get up. FM-A advised staff if R9 still was not out of bed by noon family members would come to assist with getting him up. Between 11:00 a.m. and 12:30 p.m., RN-B called to update FM-A R9 was restless so staff had gotten him up and assisted him to eat cereal and coffee. R9 then he had vomited. RN-B remarked to FM-A she didn't think he was going to last long. RN-B asked FM-A if she wanted R9 to be sent to the hospital or stay at the facility and be kept comfortable. FM-A advised RN-B to send R9 to the ER. FM-A would pick up R9's spouse and go to the hospital. Upon arrival at the ER, The family was met by the ER physician who explained R9 did not look good:. The physician explained R9 had a brain bleed, a skull fracture with probable fractures in his neck and back as well. When the family entered R9's ER room, R9 was not able to communicate and health had deteriorated. the physician had discussed options for treatment. Due to his age and medical condition, he didn't feel surgery was an option. R9's family did not want to prolong his suffering. R9 was experiencing more pain as time progressed, and had difficulty breathing. The decision was made to control R9's pain and place him on comfort cares. At around 6:00 p.m., R9 was transported back to the facility with hospice orders in place. At 7:30 p.m. R9 was at the facility with FM-A in attendance. R9's breathing sounded like gurgling. At approximately 9:00 p.m. she thought, R9 no longer was breathing, had no heart beat and was pronounced dead. FM-A was upset and reported he shouldn't have had to suffer and died . Continued interview with FM-A further identified, a couple of weeks after R9's death, she wanted to find out more about his fall and had requested a copy of his medical record. She stated the DON had returned a call to discuss R9's fall. FM-A stated the DON had described R9 was walking to the toilet when he had called out and fallen backward striking his head on the floor. FM-A stated she'd questioned why R9 had fallen so hard when staff were to have assisted him and were to use a gait belt to help him walk. FM-A stated the DON confirmed the NA assisting R9 on the morning of his fall had not used a gait belt, and had stepped away to open the bathroom door when he fell . FM-A voiced concern about whether R9 would have had appropriate assistance with walking to the bathroom, he would possibly not have fallen so hard. FM-A verified she was not made aware of the severity of R9's fall when she was initially contacted at either the 8:24 a.m. or the 10:30 a.m FM-A expressed regret about not having gone to the facility sooner, and stated she would have if she had been made aware of the severity of R9's fall with subsequent head injury. In addition, FM-A stated had she had been made aware of the severity of his injuries, she would have immediately requested he be sent to the ER. Interview on [DATE] at 11:00 a.m., with RN-B identified she was the day shift charge nurse on [DATE], working from 6:45 a.m. to 3:45 p.m. Upon arrival to the facility RN-B received report from RN-A, R9 had fallen while walking to the toilet. She was informed R9 had hit his head and was resting in bed after the fall with an ice pack on the back of his head. Upon arrival at R9's room RN-B identified R9 was talking per his usual behavior, denied pain, but had a large goose egg on the back of his head. RN-B described the lump as between golf-ball and base ball size, but made no assessment for measurements or severity of his injury. RN-B's assessments that day included vital signs, pupils, hand grasps, extremity movements, and pain which were all felt to be within R9's normal range. RN-B described the procedure for checking neuro checks as at the time of the incident, 30 minutes later, and then hourly and progressing to longer time frames. RN-B had notified FM-A around 8:00 a.m. to 8:30 a.m. that day that R9 had fallen, had a goose egg on his head but was talking and his VS and neuro's were normal. R9's VS did not become abnormal

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) until sometime after lunch. FM-A requested to be updated so she had spoken to her after VS and neuro's were taken that morning around 10:00 a.m., and reported to the family there was no change in condition. RN-B had not notified R9's physician of the fall. R9's family members requested he be sent to the ER after RN-B noticed significant changes in VS and decline sometime around 12 noon. RN-B identified she should have notified the provider on-call when there was a change in status around 9:00 a.m., but had failed to do so. R9 routinely received [MEDICATION NAME] for his history of stroke. RN-B agreed she had not identified this placed R9 at increased risk of bleeding after an injury. The facility had a policy and procedure manual located at the nursing station, in addition to multiple manuals utilized as standards of practice for care. RN-B identified an emergent situation would include a fall with new onset pain, changes in level of consciousness or VS, fever, cough, and or shortness of breath or difficulty breathing. RN-B had offered to send R9 to the ER when she had spoken with FM-A, but they wanted him kept comfortable. RN-B could not recall details of her assessment she had provided to FM-A. RN-B agreed R9's hematoma was a serious concern, but admitted she failed to contact the provider or requested ER transfer. RN-B identified the changes in VS, decreased LOC, headache, lump on back of head, emesis would all be indications of head injury. RN-B stated in hind sight, she should have contacted the on-call physician both initially when she came on duty and was made aware of his fall with head injury and again when R9 developed a change in condition. Interview on [DATE] at 1:40 p.m., with MD-A identified she had been the doctor on-call for the ER physician who providing care to R9 in the ED on [DATE], when R9 was transferred following his fall. MD-A was also the MD on call on [DATE]. As an on-call provider, her duties included to assume care for those patients who required acute admission to the hospital or ER, provide consultation if requested, and follow a patient admitted for end-of-life or hospice services. MD-A identified she should have been notified immediately after R9's fall and subsequent head injury for consultation on method of treatment. When R9 had fallen, and later when he demonstrated a change in condition at 9:00 a.m. with unequal hand grips, pupillary changes, and change in the level of consciousness, she should have been called immediately. MD-A was not able to identify the cause of the delay of approximately one hour from when FM-A requested R9 be transferred to the ER, but the usual time for EMS response from initiation of call to arrival at the ED was 30 minutes or less. Failure by he facility staff to identify and assess changes in physical and mental status, prevented critical emergency assessment, pain management and comfort measures for R9 following his significant head injury. Subsequent interview with the ADON on [DATE], at 2:20 p.m., identified the fax notification of R9's fall was sent at 7:44 a.m. on [DATE], by RN-A. The ADON agreed there were no additional updates or communication to a medical provider until the ED was contacted at 1:24 p.m. with the intent to transfer via EMS. The ADON agreed R9 had an emergent condition and stated normally, the facility process was to first check with family prior to initiating an emergency transfer. The determination to consult with the provider would be dependent on what the family wanted done with regard to resident expected outcome. The ADON identified in hind sight, the RN should have provided an update to the medical provider of R9's status immediately following a head injury and again with his change in condition. During interview on [DATE] at 3:40 p.m., MD-B (the facility's Medical Director) identified she reviewed R9's medical record following his death. R9 experienced a fall with hematoma and new onset pain or changes in condition warranted an emergency situation due to a head injury. Her expectation was the nurse on duty at the time of the fall was to have immediately notified the physician or on-call physician to identify immediate treatment need. A fax notification was appropriate for updates such as a minor fall without injury, a skin tear, or an FYI. A fall with R9's degree of severity and injury should have been communicated to the medical provider via phone at that time. The delay in notification prevented possible interventions that could have provided comfort to both the patient and family. The ultimate outcome was likely not preventable due to the severity of the fall, but earlier interventions could have been provided to ensure comfort and faster evaluation of his medical status. The MD-B identified that was not the standard she normally saw provided by the facility, and was surprised the facility had not notified the physician immediately. MD-B agreed R9 was to have assistance of 1 staff while using his walker including gait belt use for safety. R9's severity of his injuries resulting from the fall could have likely been decreased if the plan of care had been followed and the NA had not stepped away and actively assisted in R9's transfer. Review of the [DATE] and [DATE], Gait Belt and Ambulation policies identified staff would receive training in use of a gait belt during orientation. A gait belt was to be used for all residents needing assist with transfers and ambulation. Before assisting a resident with ambulation, staff were to know their resident, be alert to changes, and check the resident's care plan. While ambulating, staff were to walk beside the resident with a firm grasp on the gait belt. Review of the [DATE], Notification of Change: Significant Change policy identified residents and/or resident's representative will be notified of changes in care or condition, as appropriate. Physicians and/or delegated non-physician practitioners were to be appropriately notified of condition changes. Staff were to immediately inform the resident, consult with the resident's provider, and notify the resident's representative (s) when there was an incident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident's physical, mental, or psychosocial status to include a deterioration in health mental, or psychosocial status in either life-threatening conditions or clinical complications. The IJ was removed on [DATE] when it could be verified through documentation review and interview, the facility had revised policies for ensuring medical care would be provided timely including access to physician orders [REDACTED]. In addition, the facility's 24 hour report system was re-evaluated and staff were educated to revised processes.