STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY CARE AND REHAB LLC	**600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident's clinical record accurately reflected current wishes for resuscitation status for 1 of 1 residents (R30) reviewed for advanced directives. Findings include: R30's admission Minimum Data Set (MDS) [DATE], indicated R30 had moderate cognitive impairment, and was able to understand and be understood, and had [DIAGNOSES REDACTED]. In addition, the MDS indicated R30 required limited assistance from staff with bed mobility, transfers, ambulation, eating, personal hygiene, and toileting. R30's admission Care Area Assessment (CAA), dated [DATE], indicated R30 was alert and oriented but occasionally forgetful, and able to make her own decisions. The CAA indicated R30 needed limited assist for completion of ADL cares due to weakness. R30's care plan dated [DATE] listed R30 had completed a physicians order for life sustaining treatment (POLST) that instructed the facility staff that her wishes were for cardiopulmonary resuscitation (CPR) and her decisions would be reviewed annually at care conference and/or as needed and update. On [DATE], at 9:00 a.m during a review of R30 electronic medical record (EMR) the header information in R30's chart indicated R30's advanced directive/code status was for do not resuscitate (DNR). R30's electronic record included a scanned copy of a POLST dated [DATE], which indicated R30's advanced directive/code status was for CPR. No other POLST was found in the EMR scanned documents. On [DATE], at 10:22 a.m. during an interview with family member(FM)-A and R30, FM-A stated last week during a care conference R30 had requested her advanced directive/code status be changed from CPR to DNR. R30 verified her current advanced directive code status wishes were DNR, and stated R30 had completed out an updated form at that time. R30's progress note dated [DATE], indicated during a care conference with family, R30 had requested to update her POLST status from CPR to DNR. The progress note indicated R30 had completed a new POLST form at that time. A review of R30's orders summary report signed by the provider on [DATE], revealed R30's advanced directive/code status was CPR. Review of the facility undated document titled Nurses Notes, which listed each resident individually by name and location and listed the individual resident code status. The document listed R30's advanced directive/code status as CPR. A review of the facilities undated document identified by the facility as the nursing assistant care guide, listed R30 code status as CPR. On [DATE], at 2:33 p.m. nursing assistant (NA)-A reviewed the facility document identified as the nursing assistant (NA) care guide and stated the NA care guide had important care information on it including code status, and indicated R30's code status was CPR. On [DATE], at 2:43 p.m. director of nurses (DON) stated she recalled R30 had requested to change her advanced directive code status from CPR to DNR at a care conference on [DATE]. The DON stated R30 had completed a new POLST, signed by the provider on [DATE]. The DON verified the POLST had not been scanned into R30's EMR yet and retrieved it from a red folder in the file cabinet. The DON verified R30's care plan, nurses note sheet, and NA care guide did not accurately reflect R30's current advanced directive/code status information, and stated it should have been updated promptly. The DON indicated she would expect nurses to check the code status/POLST book at the nurses desk for all residents advanced directive/code status information. The blue 3 ring binder labeled Code Status/POLST book at the nurses desk was reviewed with the DON, and included a copy of R30's POLST form dated [DATE]. On [DATE], at 3:03 p.m. registered nurse (RN)-B stated she would look at her nurses note worksheet to identify a residents advanced directive/code status. RN-B verified she had just come on shift, reviewed the nurses shift note worksheet and stated R30's code status indicated CPR, but she would always check the code status/POLST book because it was the most up to date. On [DATE], at 3:05 p.m. RN-A stated she would always check the code status/POLST book to verify a residents code status information. A review of the facility policy titled Advanced Directive Policy/POLST, revised on [DATE], indicated the DON or assist director of nurses would update the orders in the EMR, nurses shift sheets, and NA care guides on admission and with any changes to advanced directive code status. However, the policy did not address the use of a code status/POLST book for the current code status of each resident.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to immediately report, no later than 24 hours, an injury of unknown origin to the State Agency (SA) for 1 of 1 resident (R15) who was dependent on staff for all activities of daily living, had several inner thigh bruises and was reviewed for abuse. Findings include: R15's annual Minimum Data Set ((MDS) dated [DATE], identified R15 had [DIAGNOSES REDACTED]. The MDS identified R15 had severe cognitive impairment, and required extensive assistance with activities of daily living (ADL)'s of bed mobility, transfers, eating and toileting. The MDS revealed R15 had no physical or verbal behaviors towards self or others and had no rejection of cares during the assessment period. R15's annual Care Area Assessment (CAA) dated 12/19/19, identified R15 had significant cognitive impairment, was mostly non-verbal and was not comprehensible when speaking. The CAA revealed R15 required extensive assistance with all of her ADL's and indicated staff were to anticipate R15's needs. R15's current care plan revised, 12/31/19, revealed R15 had impaired cognitive function, impaired thought process and memory impairment. R15's care plan revealed she required extensive to total assistance with all of her ADL cares which included bed mobility, transfers, eating and toileting. The care plan further revealed R15 was no longer able to verbalize her needs and wishes and indicated staff were to anticipate her needs. Review of R15's skin/wound progress notes from 1/31/20, to 3/4/20, revealed the following: - 1/31/20, R15 had bruising to her upper left arm and on her inner right and left thighs. The note revealed R15's bruising measured as follows: -right inner thigh had three (3) purple bruises which measured 3.0 centimeters (cm) in length by one (1) 1.0 cm in width, 3.0 cm by 1.0 cm and 1 cm by 1 cm. -left inner thigh had one purple bruise which measured two (2) 2.0 cm by 1.0 cm. -left upper arm had one purple bruise which measured 2.0 cm by 2.0 cm. The note indicated R15's five bruises were washed, dried, left open to air and would be monitored. R15's progress note lacked any documentation the cause of R15's five bruises, whether any other nursing staff had been interviewed, any changes in R15's mood/behavior or possible etiology of R15's bruises. Further, the note did not identify when or how R15 obtained five purple bruises on her bilateral inner thighs and upper left arm. - 2/14/20, identified R15 had yellow bruising to her inner right and left thighs were healing and had decreased in size. The note revealed R15 had no pain and all other skin was intact. -2/21/20, identified R15 had fading yellow bruising to her inner right and left thighs, current treatments included encourage repositioning, proper peri-cares, treatments as ordered. The note revealed R15 would continue to be monitored. -2/28/29, identified R15 had a

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) bruise to her right hand, healing bruises to bilateral shins and a small scab to her upper chest. The note revealed R15 had lotion applied and her fingernails trimmed. The note did not identify whether R15's bilateral inner thigh bruises had healed. R15's monthly behavior review note dated 2/4/20, revealed R15 had significantly less anxiety reported within the last month and had no reported behaviors. The note revealed R15 was more relaxed, had frequent rest periods and did not express herself verbally very much. On 3/2/20, at 6:39 p.m. R15 family member (FM)-C indicated at least one of R15's family members visited her daily and assisted with at least one meal. FM-C indicated R15 had severe dementia stated as far as he was aware R15 had no recent or current skin conditions or any injuries, which included bruising. FM-C indicated R15 had thin skin, had bruising on her hands in the past, however he did not feel it was typical for R15 to have bruising. On 3/3/20, at 1:20 p.m. R15 was lying in bed on her back, covered with a blanket from her feet to her chest. Her eyes were closed and a fall mat was observed on the floor next to her bed. R15 held a teddy bear in her arms. On 3/3/20, at 2:11 p.m. NA-D stated R15 had recent bruising on her legs, unable to recall the exact location, however she indicated the licensed nurse was already aware when she notified her. On 3/3/20, at 3:07 p.m. the director of nursing (DON) indicated the facility did not complete incident reports for skin injures such as bruising and skin concerns were tracked on an Excel spreadsheet she maintained. The DON stated all residents, which included R15, skin was checked weekly with their bath and a skin/wound note was entered into their medical record. The DON stated she reviewed all resident notes daily in the mornings for skin/wound notes. On 3/4/20, at 1:40 p.m. The DON confirmed R15's inner thighs were not a typical areas or an area prone to bruising, however did not feel R15's bruises were suspicious. The DON confirmed R15's bilateral upper thigh bruises and upper left arm bruises had not been reported to the SA. The DON confirmed R15's medical record lacked any type of incident report or investigation of the bilateral upper thigh bruising and upper left arm bruising. The DON stated she was made aware of R15's bruises the following day and the facility's interdisciplinary team (IDT) discussed the bruises the following day during stand up meeting. The DON stated R15 had periods of anxiety and liked to have her hands together between her thighs. The DON confirmed staff were not asked if they knew how R15's bilateral upper thighs and left upper arm were injured and had observed cares to see if R15 had any behaviors. On 3/4/20, at 2:18 p.m. the facility administrator confirmed he had been informed of R15's bilateral upper thigh bruising and upper left arm bruising the following day during the facility's routine daily stand up meeting. The administrator stated he expected the nursing staff to identify the origin of R15's bruises. He indicated he was not aware whether a cause or origin or R15's bruises had been identified. The administrator stated he would expect injuries of unknown origin to be reported to him immediately and the the SA within 24 hours. However, the administrator stated due to the location and extent of R15's bruising, he would have expected the incident to have been reported and investigated. Review of the facility policy titled, Abuse/Neglect Prevention Plan and Policy, revised 1/25/19, identified it was the purpose of the policy to ensure all alleged violations which involved mistreatment, neglect, or abuse including injuries of unknown source, and misappropriation of resident property were immediately reported to the administrator of the facility and to the SA. The policy identified an injury of unknown source would be classified as such when both of the following conditions were met: -the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and -the injury was suspicious because of the extent of the injury or the location of the injury (the injury was located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 resident (R15) reviewed for bilateral upper thigh and upper arm bruising and abuse. In addition, the facility failed to protect all 38 other residents who resided in the facility while the investigation was conducted. Findings include: R15's annual Minimum Data Set ((MDS) dated [DATE], identified R15 had [DIAGNOSES REDACTED]. The MDS identified R15 had severe cognitive impairment, and required extensive assistance with activities of daily living (ADL)'s bed mobility, transfers, eating and toileting. The MDS revealed R15 had no physical or verbal behaviors towards self or others and had no rejection of cares during the assessment period. R15's annual Care Area Assessment (CAA) dated 12/19/19, identified R15 had significant cognitive impairment, was mostly non-verbal and was not comprehensible when speaking. The CAA revealed R15 required extensive assistance with all of her ADL' and indicated staff were to anticipate R15's needs. R15's current care plan revised, 12/31/19, revealed R15 had impaired cognitive function, impaired thought process and memory impairment. R15's care plan revealed she required extensive to total assistance with all of her ADL cares which included bed mobility, transfers, eating and toileting. The care plan further revealed R15 was no longer able to verbalize her needs and wishes and indicated staff were to anticipate her needs. Review of R15's skin/wound progress notes from 1/31/20, to 3/4/20, revealed the following: - 1/31/20, R15 had bruising to her upper left arm and on her inner right and left thighs. The note revealed R15's bruising measured as follows: -right inner thigh had three (3) purple bruises which measured 3.0 centimeters (cm) in length by one (1) 1.0 cm in width, 3.0 cm by 1.0 cm and 1 cm by 1 cm. -left inner thigh had one purple bruise which measured two (2) 2.0 cm by 1.0 cm. -left upper arm had one purple bruise which measured 2.0 cm by 2.0 cm. The note indicated R15's five bruises were washed, dried, left open to air and would be monitored. R15's progress note lacked any documentation the cause of R15's five bruises, whether any other nursing staff had been interviewed, any changes in R15's mood/behavior or possible etiology of R15's bruises. Further, the note did not identify when or how R15 obtained five purple bruises on her bilateral inner thighs and upper left arm. - 2/14/20, identified R15 had yellow bruising to her inner right and left thighs were healing and had decreased in size. The note revealed R15 had no pain and all other skin was intact. -2/21/20, identified R15 had fading yellow bruising to her inner right and left thighs, current treatments included encourage repositioning, proper peri-cares, treatments as ordered. The note revealed R15 would continue to be monitored. -2/28/29, identified R15 had a bruise to her right hand, healing bruises to bilateral shins and a small scab to her upper chest. The note revealed R15 had lotion applied and her fingernails trimmed. The note did not identify whether R15's bilateral inner thigh bruises had healed. On 3/3/20, at 1:20 p.m. R15 was lying in bed on her back, held a teddy bear in her arms and was covered with a blanket from her feet to her chest. R15's eyes were closed, lights of her room were off and she had a fall mat on the floor next to her bed. On 3/3/20, at 2:11 p.m. NA-D stated R15 was dependent on staff for all of her ADL's which included bed mobility, transfers, eating and toileting. NA-D stated R15's needs were to be anticipated, she was unable to verbalize her needs and wishes. NA-D stated R15 had recent bruising on her legs, unable to recall the exact location, however she indicated the licensed nurse was already aware when she notified her. On 3/4/20, at 7:06 a.m. nursing assistant (NA)-E stated R15 was dependent for all of her ADL's, used a full mechanical lift with a full body sling (arms and legs remain inside the sling) for all of her transfers. NA-E stated R15 had some bruises on her legs a few weeks ago and was unsure of where R15's bruises originated from . NA-E indicated R15 had no rejection of cares and was not combative with cares. On 3/4/20, at 1:20 p.m. licensed practical nurse (LPN)-A stated she had first observed R15's bilateral inner thigh bruising and upper left arm bruising when she checked her skin after a bath on 1/31/20. LPN-A stated she had not asked R15 about the bruises and indicated R15 had severe cognitive impairment and was not a reliable historian. LPN-A indicated she had not asked any other staff if they knew how R15 sustained the bruises. LPN-A indicated she could not recall if she had notified the DON or adminstrator and did not feel R15's bruises were suspicious in nature. On 3/4/20, at 1:40 p.m. the DON confirmed R15's medical record lacked any type of incident report or investigation of the bilateral upper thigh bruising and upper left arm bruising. The DON stated she was made aware of R15's bruises the following day and the facility's interdisciplinary team (IDT) discussed the bruises the following day during stand up meeting. The DON stated R15 had periods of anxiety and liked to have her hands together between her thighs. The DON confirmed staff were not asked if they knew how R15's bilateral upper thighs and left upper arm were injured and had observed cares to see if R15 had any behaviors. The DON confirmed R15's inner thighs were not a typical areas or an area prone to bruising, however, did not feel R15's bruises were suspicious. The DON confirmed R15's bilateral upper thigh bruises and upper left arm bruises had not been reported to the State Agency (SA). During a follow up interview, at 2:15 p.m. the DON indicated the day prior to when R15's bruising was first observed, the facility had a large puppy visit, who had put its paws on R15's upper legs. The DON stated the IDT team had discussed it as a potential cause of R15's bruises when they were investigating the source of her bruising. DON offered no further information regarding investigation of bruising for R15. On 3/4/20, at 2:18 p.m. the facility administrator confirmed he had been informed of R15's bilateral upper thigh bruising and upper left arm bruising the following day during the facility's routine daily stand up meeting. The administrator stated he expected the nursing staff to identify the origin of R15's bruises. He indicated he was not aware whether a cause or origin or R15's bruises had been identified. The administrator stated he would expect injuries of unknown origin to be reported to him immediately and

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) the the SA within two hours. However, the administrator stated due to the location and extent of R15's bruising, he would have expected the incident to have been reported and investigated. Review of the facility policy titled, Abuse/Neglect Prevention Plan and Policy, revised 1/25/19, identified it was the purpose of the policy to ensure all alleged violations which involved mistreatment, neglect, or abuse including injuries of unknown source, and misappropriation of resident property were immediately reported to the administrator of the facility and to the SA and an investigation would be conducted and reported to the SA within five (5) days. The policy identified an injury of unknown source would be classified as such when both of the following conditions were met: -the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and -the injury was suspicious because of the extent of the injury or the location of the injury (the injury was located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further, identified residents were to be protected during an investigation if an employee had been identified.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facilty failed to provide assistance with grooming which included facial hair removal and nail cares for 2 of 3 residents (R15 and R18) who were dependent on facility staff for activities of daily living (ADL's). Findings include: R15's annual Minimum Data Set ((MDS) dated [DATE], identified R15 had [DIAGNOSES REDACTED]. The MDS identified R15 had severe cognitive impairment, and required extensive assistance with ADL's of dressing, personal hygiene and bathing. The MDS revealed R15 had no rejection of cares during the assessment period. R15's annual Care Area assessment dated [DATE], identified R15 had significant cognitive impairment, was mostly non-verbal and was not comprehensible when speaking. The CAA revealed R15 required extensive assistance with all of her ADL' and indicated staff were to anticipate R15's needs. R15's current care plan revised, 12/31/19, revealed R15 required extensive to total assistance with personal hygiene, dressing, and bathing. The care plan revealed R15 was no longer able to verbalize her needs and wishes and indicated staff were to anticipate her needs. The care plan did not identify R15's facial hair removal or shaving needs. On 3/2/20, at 12:44 p.m. R15 was seated in a wheelchair in the dining room at a table with three other residents and staff members. R15 had patches of several thick, coarse, black facial hairs approximately three (3) to six (6) millimeters (mm) along her chin and jaw line. On 3/2/20, at 6:39 p.m. family member (FM)-C indicated at least one of R15's family members visited her daily and assisted with at least one meals. FM-C indicated R15 had severe dementia and continued to decline physically. FM-C stated R15's grooming and personal appearance had been important to her prior to her memory loss and felt R15 would want to look her best when she interacted with others. FM-C stated he routinely assisted R15 with her evening meal and R15 routinely had flat hair on the back of her head (bed head,) indicated he combed the back of her hair when he arrived. FM-C stated he had noticed R15 had several facial hairs which he felt would have bothered her if she knew they were there. He indicated he would want staff to check her face for any facial hairs and remove them as needed. FM-C stated R15 had a razor and had not been notified anything had happened to it. On 3/3/20, at 8:40 a.m. R15 was lying on her back in bed, covered with a blanket from her feet to her torso, her eyes were closed. R15 continued to have patches of several thick, coarse, black facial hairs approximately 3 to 6 mm along her chin and jaw line. At that time, the assistant director of nursing (ADON) and R15's primary physician entered her room for a routine visit. On 3/3/20, at 1:20 p.m. R15 was lying on her back on her bed, covered with a blanket from her feet to her mid chest. R15 continued to have patches of several thick, coarse, black facial hairs approximately 3 to 6 mm along her chin and jaw line. On 3/4/20, at 7:06 a.m. R15 was lying in bed on her back, at that time nursing assistant (NA)-E and NA-J entered her room and proceeded to assist with morning cares. R15 was assisted from her bed to a wheelchair, at that time, NA-E confirmed R15 had patches of several thick, coarse, black facial hairs approximately 3 to 4 mm along her chin and jaw line. NA-E stated R15 usually had her facial hair removed daily, and proceeded to shave R15 with her personal electric razor. NA-E indicated R15's razor did not work well and indicated R15 continued to have several thick, black, coarse chin hairs which were approximately two (2) to 6 mm in length. NA-E stated she would inform the nurse to notify R15's family member she needed a new razor. On 3/4/20, at 1:20 p.m. licensed practical nurse (LPN)-A stated R15 was totally dependent on staff for all of her ADL's which included facial hair removal. LPN-A stated she would expect R15's facial hair to be removed daily with cares and weekly with her bath. LPN-A stated R15's family members come to see her daily and felt they would have no problem obtaining another razor for her. On 3/4/20, at 1:40 p.m. R15 was lying in bed on her back, eyes were closed and she was covered with a blanket from her feet to her mid chest with the director of nursing (DON) present in the room. She confirmed R15 had patches of several thick, black, coarse facial hairs on her chin and jaw line which were approximately 3-4 mm in length. The DON confirmed R15's care plan identified she required extensive to total assistance with grooming and personal hygiene. The DON confirmed R15's care plan did not specifically identify facial hair removal, however, indicated it was a standard with daily cares. R18 R18's quarterly Minimum Data Set ((MDS) dated [DATE], identified R18 had moderate cognitive impairment and [DIAGNOSES REDACTED]. R18's MDS further identified she required assistance with hygiene, toileting and transfers, and was independent with eating. R18's activities of daily living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 6/16/19, identified R18 had dementia, depression, mood disorder and [MEDICATION NAME] degeneration. R18's CAA further identified she also had unsteadiness with gait and transfers. R18's CAA identified she had a need for physical assistance to complete ADL cares and was able to feed self. R18's CAA indicated she preferred a fairly established pattern of activity. R18's care plan, revised 4/2/19, identified R18 had a self-care performance deficit related to impaired cognition, behaviors and impaired vision. R18's care plan identified she required assistance with bathing, dressing, personal hygiene and toileting. R18's care plan interventions included; assistance with washing hands and combing hair and to check nail length and to trim and clean on bath days and as necessary. R18's care plan identified she had behavioral disturbance related to dementia with behaviors listed, which included digging in rectum and resisting direction/assistance for basic care needs. On 3/2/20, at 1:01 p.m. R18 was in her room, in her recliner. R18's fingernails were painted and had brown substance under multiple fingernails, her left hand had brown substance noticeably under her pinky and ring fingernails, and her right hand had brown substance under her thumb and ring fingernails. R18's hair was flat and matted with some areas sticking straight out in the back and right side of her head, and her hair appeared uncombed. At 5:49 p.m. R18 was in the dining room feeding self, and her hair remained uncombed. On 3/3/20, at 8:45 a.m. R18 was in the dining room, sitting in a chair at a table. R18's hair continued to appear uncombed, and was flat and matted with some hair sticking straight out on the right side and back of her head. On 3/3/20, at 1:15 p.m. R18 was in the recliner in her room, lap blanket on her lap, dressed in street clothes. R18's hair remained the same, flat and matted on the right side and back of her head with hair sticking straight out on her right side and back of head. R18's fingernails continued to have brown substance under 2-3 fingernails on each hand. At 1:20 p.m. nursing assistant (NA)-A briefly entered R18's room talked with her and then exited the room. NA-A did not assist R18 with combing her hair or cleaning under her fingernails. At 2:08 p.m. another unknown staff member entered her room, assisted R18 to take a drink of water, and immediately left the room without assisting R18 to comb her hair or clean under her fingernails On 3/4/20, at 7:38 a.m. R18 was in her room with night clothes on, she indicated she was going to get a bath soon. At 8:38 a.m. R18 was seated in a chair next to a table in the dining room. R18's hair still appeared messy, with hair sticking out on the right side and back. Review of R18's progress notes from 12/2/19, to 3/4/20, identified on 2/16/20, at 10:21 p.m. R18 was digging in her groin/buttocks area on the toilet while the nursing assistant was getting her ready for bed. R18 was told not to continue that behavior and her nails were cleaned, as this was identified as a potential infection control issue. On 3/3/20, at 2:37 p.m. NA-A indicated R18 had a history of [REDACTED]. NA-A indicated the last time she had witnessed this behavior was in August. NA-A indicated R18 received a bath every Wednesday and would get her hair done at the beauty shop after her bath. NA-A indicated R18 was very particular about her hair, NA-A indicated R18's hair looked messy, and R18 had refused to allow her to comb her hair that morning and had she had not attempted to comb her hair the rest of the day. On 3/3/20, at 2:48 p.m. registered nurse (RN)-B was present in R18's room. RN-B observed R18's fingernails and confirmed they needed to be cleaned. RN-B indicated they would get an orange stick (manicure tool used to clean fingernails) to clean under R18's fingernails, which were available for staff to use and confirmed R18 had a history of [REDACTED]. RN-B confirmed R18's hair appeared uncombed and messy. On

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) 3/4/20, at 1:19 p.m. during a telephone interview family member (FM)-A indicated it was very important for R18 to have her hair neat and her nails done. FM-A indicated it was especially important to R18 that her hair was neat, and that was why she went to the beauty shop every week. FM-A indicated R18's hair would get flat in the back at times, and she did not comb it herself. FM-A indicated the family members would comb her hair and fluff it up before they took her on outings. FM-A indicated he and R18's brother had discussed R18 having gunk under her fingernails and had spoken to the facility about their concern and indicated they felt it was not sanitary. On 3/4/20, at 2:32 p.m. NA-B indicated R18 did not like her hair combed, but would let them do it lightly and in the back. NA-B indicated R18 usually went to the beauty shop weekly, but the beautician had been unavailable the present week. NA-B indicated her usual practice for resident nail care was to clip and deep clean fingernails on bath days, and to use a nail brush and clean them between the bath days if needed. On 3/4/20 at 2:49 p.m. director of nursing (DON) indicated she would expect every residents' hair to be combed with morning and evening cares. DON indicated R18 required a lot of encouragement to complete cares and indicated she would expect nursing staff to comb R18's hair and to clean under R18's fingernails as needed. DON indicated the facility had orange sticks available to use to keep fingernails clean also. DON indicated residents' fingernails needed to be kept clean for infection control. A facility policy titled, Resident Personal Cares-AM & PM, revised 1/18/19, identified it was the policy of the facility that all residents received personal cares twice daily to maintain health, hygiene and dignity. The policy revealed various procedures for assisting with personal cares which included grooming. The policy revealed residents hair would be combed, females would have whiskers shaved in accordance to their preferences.
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 ensure an environment free from accident hazards during the use of mechanical lifts for resident transfers for 1 of 1 resident (R14) reviewed who required the use of mechanical lift, did not have the sling safety safety strap secured and had a fall with a major injury. This deficient practice caused actual harm to R14 who was propelled out of the wheelchair when the sling strap caught on the wheel of the wheelchair, and fractured her femur. The facility had implemented corrective action so the deficient practice is being issued at past non-compliance harm level. Findings include: R14's quarterly Minimum (MDS) data set [DATE], identified R14 had [DIAGNOSES REDACTED]. The MDS identified R14 was cognitively intact and required extensive assistance with activities of daily living (ADL's) which included bed mobility, toileting and was totally dependent with transfers. The MDS identified R14 had functional limitation in range of motion (ROM) of both upper and lower extremities and used a wheelchair. The MDS identified R14 had no falls since her last MDS assessment and had no major surgeries within the last six months. R14's annual MDS dated [DATE], identified R14 had [DIAGNOSES REDACTED]. The MDS identified R14 was cognitively intact and was totally dependent for transfers. The MDS revealed R14 had functional limitation in range of motion of both upper and lower extremities and used a wheelchair. Further, the MDS identified R14 had a fall with a major injury (fracture.) R14's annual Care Area Assessment (CAA) dated [DATE], identified R14 had a [DIAGNOSES REDACTED]. The CAA identified R14 was chair bound and required extensive assistance with ADL's and the use of a full mechanical lift for transfers. The CAA identified R14 had suffered a fractured leg as a result of a fall from the wheelchair on [DATE], which was not surgically repaired. The CAA revealed R14 was transported in the corridor in her wheelchair when she had fallen and indicated she was unable to work with physical therapy due to the unstable fracture. R14's current care plan, revised [DATE], revealed R14 required assistance of two staff and a full mechanical lift for transfers. The care plan revealed R14 preferred the full sling and indicated the full sling was to be kept under R14 when she was in a wheelchair. R14's care plan did not address her fall risk or recent fracture. R14's undated nursing assistant care guide revealed R14 required assistance of two with a Hoyer lift (full mechanical lift) for transfers, was non-ambulatory and used a wheelchair. The NA care guide did not address the lift sling or placement of sling straps. On [DATE], at 12::47 p.m. R14 was seated in a cushioned wheelchair in her room, faced her bed and had her eyes closed. R14 stated she had very touchy joints was at risk for fractures and dislocations due to her progresive joint and skeletal disease, which she had since she was born. R14 stated she was unable to bear any weight on her legs and required the use of a mechanical lift for all of her transfers. R14 pointed to the seat of her wheelchair which revealed a blue fabric mechanical lift sling with the straps tucked on either side of her upper thighs and armrest of the wheelchair. R14 stated she always had the sling underneath her and the nursing staff would attach the straps to the mechanical lift when she needed to transfer. R14 stated she had been flung out of her wheelchair in [DATE], when one of the straps caught in the front wheel when a nursing assistant (NA) wheeled her out to the dining room. R14 stated she had sustained an inoperable fracture of her left femur. R14 stated she had a history of [REDACTED]. She indicated she could not recall if the NA had tucked the sling straps alongside the armrests of the wheelchair prior to the transport, however, stated since she returned from the hospital the facility's nursing staff made sure the sling straps were tucked alongside her and the armrest of the wheelchair before they assist her with transport. On [DATE], at 5:27 p.m. NA-G indicated she had worked with R14 when she had fallen out of the wheelchair and sustained a fracture. NA-G indicated she felt R14's sling straps were secure prior to her wheeling R14 out of her room and into the hallway, and could not recall if she had physically tucked in R14's sling straps prior. NA-G indicated R14's wheelchair had abruptly stopped, R14 fell forwards out of the wheelchair and the sling strap was caught on the front wheel of her wheelchair. She indicated R14 had complained of pain to her left hip/leg area. NA-G stated she was unsure of how the straps had come loose and became lodged in the wheel of the wheelchair. NA-G stated immediately following the incident, she received education to ensure sling straps were secure in residents wheelchairs, which included R14, prior to transport. On [DATE], at 8:37 a m. R14 was lying in bed on her back, eyes open, covered with a blanket from her feet to her mid chest. At that time, NA-D and NA-C entered R14's room with a full mechanical lift. NA-D and NA-C proceeded to place a full bodied sling underneath R14 and assisted her to transfer from her bed to a wheelchair. NA-D then proceeded to carefully tuck the bilateral lift straps alongside R14's upper thigh and the arm rest of her the wheelchair. NA-C then proceeded to assist R14 with morning cares and wheeled her to the dining room. On [DATE], at 8:43 a.m. NA-D stated R14 was totally dependent for transfers and used a full mechanical lift with a full body sling. NA-D stated she R14's sling remained underneath her while she was in the wheelchair due to the type of sling she used. NA- D indicated she had received education after R14's fall in [DATE], to ensure the sling straps were tucked in on the sides of R14 to prevent entanglement with the wheels of her wheelchair. On [DATE], at 2:04 p.m. NA-H stated she ensured R14's sling straps were tucked in on both sides and had received education regarding sling strap placement in August of 2019, following R14's fall from her wheelchair. On [DATE], at 2:33 p.m. NA-A stated residents who required the use of the Hoyer lift had full bodied slings which remained in the wheelchairs underneath the resident, which included R14. NA-A stated she had received education regarding sling strap placement in August of 2019, following R14's fall from her wheelchair. She stated she made sure sling straps were secure prior to transport for residents were used the full body lift sling. R14's fall note dated [DATE], identified R14 had been seated in a wheelchair, wheeled down the hallway by an nursing assistant (NA) to supper when she fell from her wheelchair and landed on her left side. The note revealed R14 had hit her head, had pain on her left thigh which was warm and swollen. The note indicated R14 was assisted off of the floor with a Hoyer lift (full body lift) and had been sent to the emergency room . R14's Hospital History and Physical (H&P) dated [DATE], revealed R14 had fallen from her wheelchair when she was transported in the wheelchair by a facility staff member. The H&P revealed R14 had x-rays which revealed the following; - left second finger fracture at the base of the finger -left [MEDICAL CONDITION] at the distal end of left hip arthroplasty. R14's Hospital Discharge Summary dated [DATE], revealed R14 was admitted to the hospital on [DATE], with a left periprosthetic femur fracture (broken bone that occurs around the implants of a total hip replacement, a serious complication that most often requires surgery.) The H&P revealed R14 a [DIAGNOSES REDACTED]. The H&P indicated R14 had refused amputation of her leg, refused surgical repair of the fracture due to health complications and had opted for medical management. The H&P revealed R14's hospitalization course was complicated with the following; blood loss [MEDICAL CONDITION] which required transfusion, hemorrhagic shock, acute kidney injury, acute hypoxic [MEDICAL CONDITION] secondary to fluid overload and narcotic use. R14's internal investigation form included a 5 day summary dated [DATE], which revealed R14 fell from the wheelchair when she was wheeled down the hallway by an NA when the wheelchair came to an abrupt stop. The cause of the wheelchair to stop was the sling strap became entangled in the front wheel of her wheelchair. The summary revealed R14 had fallen on her left side and had been transported by ambulance to the emergency room . R14's internal fall investigation

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	245281	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) form revealed all staff were educated to ensure sling straps were secure as of [DATE], and the facility mechanical lift policy had been updated. Review of the mechanical lift operating manual titled, Invacare Reliant 450 RHL450-I, identified instructions/directions for using the lift to transfer residents from one a lying to a seated position. The manual identified full body slings were to remain underneath residents when seated in a wheelchair or other surface. The manual did not address sling strap placement. On [DATE], at 10:03 a.m. a telephone interview was conducted with Direct Supply representative. She confirmed the facility's mechanical lift, Invacare, full bodied sling was to remain in position, underneath a resident when seated in a wheelchair type device. She confirmed the operating manual did not indicate or address sling strap placement. The representative stated she felt it was common sense to ensure sling straps were secured prior to resident transport. Review of the facility policy titled, Mechanical Lift Policy, revised [DATE], revealed the following procedure for Hoyer slings; top sling straps should be secured to push handles on the back of the wheelchair, bottom sling straps should be rolled and tucked between wheelchair cushion and side of armrest. On [DATE], at 10:34 a.m. the director of nursing (DON) confirmed R14 had a fall from her wheelchair when the strap of her full body sling became entangled in the front wheel of her wheelchair. The DON stated she had been unable to determine how R14's full body sling strap had come loose, however she had immediately re-educated the NA who witnessed the incident, and then all other nursing staff to ensure resident sling straps were secure prior to transport. The DON confirmed the facility had updated the mechanical lift policy following R14's fall from the wheelchair on [DATE]. The DON stated the policy was updated to include ensuring sling straps were secured following mechanical lift transfer. On [DATE], at 2:23 p.m. the facility administrator stated he had been immediately notified of R14's fall and subsequent fracture and hospitalization . The administrator stated he was aware R17's sling straps had caught on the wheel of her wheelchair and felt R14's fall had been a complete accident. He indicated he did not feel the NA or the facility was responsible for R14's fall or her injuries. Facility policy titled, Fall Prevention Program, revised [DATE], identified the purpose of the policy was to provide safety to residents by the following; evaluating the environment, awareness of risks and potential hazards and to establish systems to keep residents safe. The past non-compliance that began on [DATE], was verified during the [DATE], onsite visit and was corrected by the facility on [DATE]. The verification of corrective action was confirmed by interview with a variety of nursing staff, observation of residents who used full body slings and documentation of education provided the nursing staff. In addition, the facility updated the Mechanical Lift Policy to address Hoyer strap placement. The facility identified all nursing assistants and nurses were re-educated on the updated facility's mechanical lift policy to address Hoyer sling straps by [DATE].
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement a system to ensure medications were available to administer as ordered for 2 of 2 residents (R22, R233) identified who did not recieve medications as ordered. Findings include: R22's annual Minimum Data Set ((MDS) dated [DATE], identified R22 had severe cognitive impairment and [DIAGNOSES REDACTED]. R22's MDS further identified she required extensive assistance with toileting, dressing and hygiene. R22's care plan revised 2/11/20, identified R22 had self care performance deficit related to weakness and cognitive deficit. R22's interventions instructed staff to assist with toileting, bathing, dressing and personal hygiene. R22's care plan further identified she had bowel incontinence related to impaired cognition and diarrhea/frequent oozing of stool. R22's interventions indicated to give medications as ordered. R22's Order Summary Report signed 1/15/20, included the following orders: -[MEDICATION NAME] Clear & Natural Powder. Give 1.5 tablespoons by mouth every 24 hours related to diarrhea, unspecified, start date 8/16/19 -[MEDICATION NAME] Clear & Natural Powder. Give 1.5 tablespoons by mouth every 24 hours related to noninfectious gastroenteritis and [MEDICAL CONDITION] unspecified, start date 8/16/19 Review of R22's progress notes from 3/1/20, to 3/5/20, identified the following: -3/1/20, at 2:08 p.m. R22 is out of [MEDICATION NAME] and pharmacy reported that it is too early to be filled by insurance. Will continue to monitor stools. -3/3/20, at 9:20 a.m. R22's [MEDICATION NAME] was not able to be filled until the 6th of March. Will continue to monitor. R22's progress notes did not include documentation PCP-A was notified that R22's [MEDICATION NAME] medication was not available. Review of R22's Medication Administration Record [REDACTED]. RN-B indicated she had checked and it was the same medication, so she felt it was alright to administer to R22. RN-B confirmed that was the only time R22 had received her [MEDICATION NAME] medication since it was last given 2/29/20, on the evening shift. She confirmed R22's MAR. RN-B indicated if a medication was not available to give, the usual facility process was to contact the pharmacy and wait for the medication to be delivered. RN-B indicated that at times residents in the facility ran out of medications and indicated it occurred at least three times a week. At 3:54 p.m. during follow up interview, RN-B stating the facility had an emergency kit which included critical medications such as [MEDICATION NAME] (blood thinner), pain medications and antibiotics. RN-B indicated she felt residents did not run out of critical medications and indicated the usual medications residents did not receive were over the counter medications. On 3/5/20, at 10:29 a.m. RN-C indicated she felt it was rare for a resident to run out of a medication, and the reason was usually if the pharmacy had to order in the medication, waiting for prior authorization for the medication or it was too soon to re-order. She indicated if a medication was not available to give, staff would notify the physician and get an order to either hold the medication until it was available, get a substitute order or an order to discontinue the medication. RN-C confirmed R22 did not have [MEDICATION NAME] available to give in the facility, and it would not be received in the facility until 3/6/20. RN-C indicated staff had verbally informed primary care physician (PCP)-A during his rounds, and he indicated it was fine to hold it until it was received. RN-C confirmed R22 lacked documentation for an order to hold the metamusil. On 3/5/20, at 11:42 a.m. during telephone interview, pharmacy consultant (PC)-A indicated she would expect the nursing staff to contact the pharmacy if a medication was not available to administer to a resident. PC-A indicated if it were for insurance reasons or waiting for a prior authorization she would expect the facility to contact the physician for further orders. PC-A indicated she could not imagine the pharmacy could not supply [MEDICATION NAME], and worse case scenario could charge the resident or facility for the medication. PC-A indicated it was the facility policy not to use other resident's medications, she would not expect a nurse to give R22 someone else's [MEDICATION NAME] and indicated the facility could contact the physician to get a hold order on the medication until it could be received by the pharmacy. On 3/5/20, at 11:14 a.m. R22's primary care physican (PCP)-A indicated he would expect the facility to notify him if a resident's medications were not available to administer. PCP-A indicated he could not remember if he was informed of R22 being out of [MEDICATION NAME] during rounds. PCP-A indicated if he gave verbal instructions to hold a medication, he would expect it to be documented as a verbal order. On 3/5/20, at 11:29 a.m. licensed practical nurse (LPN)-A indicated if a medication was not available, her usual practice included calling the pharmacy then to notify the director of nursing (DON), or assistant director of nursing (ADON). LPN-A indicated she would then monitor the resident for the condition the medication was ordered for. LPN-A indicated another resident in the facility, R233, also did not have a medication available to administer. LPN-A indicated R233 did not have [MEDICATION NAME] (medication to treat symptoms of [MEDICAL CONDITION] reflux disease and other conditions caused by excess stomach acid). LPN-A indicated the medication required prior authorization and when she contacted the pharmacy that day and was informed the prior authorization form was sent to the wrong physician. LPN-a indicated DON and ADON were aware. LPN-A indicated if the physician gave a verbal order, she would expect documentation of the order in the chart. R233's admission MDS dated [DATE], identified was in a persistent vegetative state with no discernible consciousness and had [DIAGNOSES REDACTED]. R233's MDS further identified R233 required total assistance with activities of daily living (ADLs), had a feeding tube, and required oxygen therapy, suctioning and [MEDICAL CONDITION] cares. R233's Order Summary Report signed 2/7/20, included order for [MEDICATION NAME] suspension 2 mg(milligram) / ml (milliliter) to give 10 ml via J tube (surgically placed tube through the abdomen into the midsection of the small intestine) in the morning related to [MEDICAL CONDITION] reflux disease without esophagitis. Review of R233's progress notes from 2/6/20, to 3/5/20, revealed the following; -2/6/20, at 12:36 p.m. R233 arrived at the facility -2/9/20, at 6:49 a.m. waiting for prior authorization for [MEDICATION NAME] from TWD (Thrifty White Drug pharmacy) -2/11/20, at 9:30 a.m. R233 seen by PCP-A, sent to the emergency room . -2/21/20, at 2:51 p.m. R233 returned from hospital No further documentation noted since 2/9/20, related to R233's [MEDICATION NAME] not available. R233's progress notes also failed to include documentation that PCP-A was notified R233's [MEDICATION NAME] medication was not available. Review of R233's February MAR indicated [REDACTED]. DON then indicated if the pharmacy was unable to deliver the medication, she

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) would expect the nursing staff to inform PCP-A during rounds and obtain a verbal order. DON indicated the medication should be put on hold, and it should be documented in the resident's chart that they were waiting for pharmacy. DON and ADON indicated they both were aware R22 did not have [MEDICATION NAME] to administer. ADON confirmed she had contacted R22's pharmacy and notified PCP-A during rounds, but confirmed she had not documented a verbal order to hold R22's medication. ADON indicated she was aware R233 had not received [MEDICATION NAME] since admission. ADON indicated she had contacted the pharmacy today and the pharmacy had sent R233's [MEDICATION NAME] prior authorization form to the wrong physician, instead of PCP-A. ADON indicated the pharmacy gave her a recommendation for an alternative medication to administer for R233 instead of the [MEDICATION NAME] and was going to discuss the recommendation with PCP-A on 3/5/20. DON indicated she would expect nursing staff not to borrow medications from residents who were discharged . DON indicated the facility had an emergency kit for medications as needed, and it was not the facility's usual practice to borrow medications from discharged resdients, which should be returned to pharmacy or destroyed. The facility policy provided titled Thrifty White Pharmacy Pharmacy Services Prescriber Medication Orders revised November 2015, identified perscription orders were required for all non-perscription medications for residents who receive medication assistance from staff. The policy further indicated no resident shall be permitted to use or take another resident's prescription medication. The facility policy provided titled Thrifty White Pharmacy Pharmacy Services Ordering And Receiving Medications From The Dispensing Pharmacy revised June 2015, identified a request for refills of current medications are either written on a medicaiton reorder form or the reorder sticker is placed on the reorder form. The policy failed to include a process for medications ordered and not received.