STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	08/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure care planned fall prevention interventions were followed for 1 of 3 residents (R2) reviewed for falls. R2 sustained harm when the care plan was not followed, R2 fell and sustained a pelvic fracture. However, the facility took immediate corrective action, therefore this is being cited at past non-compliance. Findings include: R2's admission Minimum Data Set ((MDS) dated [DATE] included, severe cognitive impairment with [DIAGNOSES REDACTED]. R2 was unsteady with transfers and required 2 plus physical assist with transfers and ambulation. R2's fall Care Area Assessment (CAA) dated 7/1/20, included being at risk for falls related to a fall prior to admission which resulted in a left femur fracture. Other risk factors included, severe cognitive impairment, weakness, impaired balance, cardiac and respiratory impairments, incontinence, use of [MEDICAL CONDITION], cardiac and diuretic medications and behavior concerns. R2's progress note dated 8/1/20, included, Pt (patient) was found sitting on the floor with her back against the front of the reclining chair. Pt is unable to give specific data on what she was trying to do that caused her to fall. After assessment, pt was picked up from the floor using the full mechanical lift. An immediate intervention was, Pin call light on pt. An interdisciplinary note, dated 8/3/20, noted, Root cause analysis: Pt was trying to get comfortable when she slid out of the chair. Intervention based on root cause analysis. Ensure legs are elevated in recliner when not eating. Evaluation of intervention: Pt states she is more comfortable with her feet up. R2's Falls Follow Up Form dated 8/1/20, included R2 had fallen and the, Short Term Intervention was to, Clip call light on Pt (patient). This form was updated on 8/3/20, and included, Ensure foot rest of recliner is up, except meal times. Pt tends to lean back and slide he (sic) butt forward trying to get comfortable. R2's risk for falls care plan dated 8/21/20, directed staff to keep call light within reach, Check my O2 sats (oxygen level) before I get out of bed in the morning, and, Ensure my feet are elevated in the recliner except during meal times. R2's care plan also addressed sleep apnea and directed staff to use a [MEDICAL CONDITION] machine (continuous positive airway pressure machine that aides in breathing for obstructive sleep apnea) at night, but often refuses to use it. R2's Pathway RA (resident assistant) Group Sheet, dated 8/19/20, directed staff, Ensure legs elevated in recliner when not eating. Keep walker within reach. R2's progress note, dated 8/15/20, included, Resident observed on floor at 0840 (8:40 a.m.) after writer heard sound of fall and resident shouting for help. Resident states she hit her head, no swelling noted, resident denies tenderness to palpitation of entire head area. Resident able to move all extremities PR (pulse rate) BP (blood pressure) stable. Resident alertness and communication pattern at baseline for resident, PERRL (pupils equal, round, and reactive to light). Resident assisted from floor to recliner using Golvo lift (mechanical lift) A2 (assist of two staff). Resident tolerates transfer with no complaints of pain. Intervention based on root cause analysis: Foot rest elevated per care plan after transfer to chair. ST (short term) intervention: Leave walker adjacent to resident. and Describe Injury: Denies headache or tenderness. Moves all extremities. Resident pleasant with staff this shift. Writer attempted to assist resident to standing position and to ambulate before lunch. Resident demonstrates pain upon standing and is unwilling to take a step due to fear of pain. The note identified a nurse practitioner was notified and lab work for R2's blood thinner and an X-ray was ordered. R2's x-ray, dated 8/15/20, noted, Right superior and inferior pubic ramus (pelvic) fracture. R2's nurse practitioner progress note dated 8/17/20, identified, 8/15 had fall from recliner. Staff reports that usually they have legs elevated but recliner was left down and the patient attempted to self transfer. Oximeter initially read 75-85% but later was 90%. CXR (chest x-ray) done showed chronic lung findings with developing LLL (left lower lobe) infiltrate. 8/16 sent to Methodist ED (emergency department) for concerns of hip pain/right groin pain and not wanting to bear weight. Recent left [MEDICAL CONDITION] with repair 6/19. At Methodist-right pelvic fracture, no issues with hip replacement. COVID negative. CT (cat scan) head negative for acute changes. Returned to facility same day. R2's investigation report from the fall on 8/15/20, dated 8/21/20, included, RA (resident assistant) indicated that she did not elevate footrest of the recliner upon leaving VA's (vulnerable adult) room per the VA's previously stated preference and care plan. During the interview with the resident assistant (RA) on duty at the time of the fall, the RA described helping the VA with AM cares and toileting prior to assisting VA to recliner. The RA placed the tray table on the side of recliner and call light within reach. The RA then left to retrieve the VA's breakfast tray. The VA was heard yelling by the nurse on duty and was found on the floor between the bed and the recliner. The VA was unable to verbalize what she was trying to do at the time of the fall. The RA noted upon her return to the resident that she had been gone approximately 2 minutes. Medical record review and nurse interview indicated that the VA experienced a period of decreased saturations (75%-85%) (normal oxygen saturation level 95-100%) noted during vital signs check after the fall. The nurse verified with 4 different oximeters and was able to obtain a reading of 90% after a period of time. The Nurse noted 'they started low and slowly went up.' The On-call MD was updated and orders for chest x-ray and COVID-19 swab were given and carried out. The NP (nurse practitioner) indicated that the VA has a history of Obstructive Sleep Apnea and refusal of wearing [MEDICAL CONDITION] and that this may have been a contributing factor to the low O2 level (oxygen level) The Director of Nursing interviewed the NP and she assessed VA on 8/17/2020 and VA was not symptomatic for pneumonia or other respiratory illness. A review of the progress notes indicated that overnight VA had displayed confusion, restlessness and combative behaviors. [MEDICAL CONDITION] medication was increased after a failed GDR (gradual dose reduction) on 8/7/2020. The RA noted that VA was not wearing her [MEDICAL CONDITION] when she initiated AM (morning) cares. During RA interview, RA indicated that she did not elevate footrest of the recliner upon leaving VA's room per per the VA's previously stated preference and care plan. The RA also stated that when she left the room, the VA did not recall that her assistive device was in within (sic) reach. The RA stated, I didn't do it on purpose, It just escaped my mind. When asked if RA knew the VA's care plan, she responded yes. She also verbalized carrying the assignment sheet on the day of the fall and previously demonstrating the ability to adhere to the care plan. Upon return from the ER (emergency room), the intervention implemented was to ensure assistive devices are within reach. After further investigation, root cause of the fall was determined to be low saturations due to VA refusal of [MEDICAL CONDITION] overnight. Intervention is for an overnight oximetry (oxygen level) study to be completed and staff to check oxygen saturations prior to assisting VA out of bed for morning cares. The RA was immediately placed on administrative leave and remains on leave while termination is in process. Facility education was completed on following the care plan. Random audits will be completed on each household on a weekly basis to ensure compliance with education. Oximeters were checked and are all functioning properly. The NP ordered an overnight oximetry study to be completed to determine the need for supplemental oxygen. The VA remains in the facility and is currently utilizing the stand lift with assist of one and is participating in therapy for rehab. When interviewed on 8/27/20, at 10:50 a.m. licensed practical nurse (LPN)-A stated, R2 needed to have her feet elevated when she was sitting in the recliner for her safety and comfort. Otherwise, R2 sat at the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) edge of her chair making her at risk for falling. When observed on 8/27/20, at 11: 56 a.m. nursing assistant (NA)-A was observed assisting R2 with transferring from her recliner to the toilet. NA-A lowered the feet to the recliner. R2 was seated on a cushion in the chair. With the foot of the recliner down, R2 stiffened up her body, with her feet and legs up and angled, pointed away from recliner and upper body leaning back, but not against recliner. R2 verbalized, oh, oh, oh. NA-A assisted R2 with transferring to the toilet and then back to the recliner. Upon returning to the recliner, R2 sat on the edge of the recliner with her feet off the floor and stiffened up again. NA-A prompted R2 to scoot back in the chair. NA-A did not scoot back in the chair. NA-A advised R2 he would put the recliner feet up and elevated R2's feet and legs. Once the foot rest was elevated R2 appeared to sit comfortably in the chair. When interviewed on 8/27/20, at 12:05 p.m. NA-A stated. R2 had to have the recliner legs up or R2 would think she could stand, R2 may also slide and was apt to fall out of the chair when the foot rest was down. Stating, R2 was evidently more comfortable with the foot rest elevated. When interviewed on 8/27/20, at 1:44 p.m. NA-B stated she had worked with R2 on 8/15/20. NA-B stated she had prepared R2 for her meal by placing the foot rest down and placed a tray table in front of her, then left the room to obtain the meal tray. She was gone for a couple minutes and when she returned, R2 had fallen out of the chair. NA-B stated R2's care plan directed the foot rest be elevated unless R2 was eating, but she had forgotten to make sure it was elevated when she left R2 alone. When interviewed on 8/27/20, at 2:59 p.m. Registered nurse (RN)-A stated she was working at the facility on the day of R2's fall, 8/15/20. RN-A stated she had assessed R2 after the fall on 8/15/20, and noted no injuries, but later in the day R2 was hesitant to stand up and reported groin pain. RN-A contacted the physician and received an order for [REDACTED]. The first fall on 8/1/20, R2 slid out of the recliner as she was trying to get comfortable. RN-B explained R2 tended to like to lean back and adjust herself that way. R2's, butt was way too close to the end of the chair when she sat down. Following the fall on 8/1/20, an intervention was added to elevate feet when R2 was not eating. RN-B explained R2's recliner foot rest should be up unless she was eating, including when staff left room to get R2's meal trays. When interviewed on 8/28/20, at 8:58 a.m. the director of nursing (DON) reported the facility determined R2's recliner foot rests were not elevated at the time R2 fell on [DATE], and should have been. The DON stated R2's oxygen level related to her not wearing her [MEDICAL CONDITION] contributed to the fall. Immediately, the facility re-educated all nursing staff on ensuring each resident's care plan was being followed and started audits to ensure compliance. The audits were for any resident at risk for falls to ensure their care planned interventions were being followed. The facility fall prevention and management program policy, last revised, 10/2018, directed staff, Care plans will indicate the resident specific interventions to prevent falls. Nursing staff will implement interventions according to resident specific risk factors. The past non-compliance that began on 8/15/20, was verified during the 8/31/20 onsite visit and was corrected by the facility on 8/16/20. Verification of the corrective action was confirmed by interview with a variety of nursing staff who had received education on ensuring fall prevention interventions were always implemented. In addition facility documentation showed staff had been trained and audits were being completed to ensure fall interventions were being implemented.