STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 55792

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

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F 0689 **Level of harm -** Minimal harm or potential for 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 a thorough and timely root cause analysis was completed to prevent further falls for 1 of 3 residents (R1) reviewed for accidents. In addition, the facility failed to ensure care-planned interventions were implemented to prevent further falls for 1 of 3 residents (R3) reviewed for falls. Findings include: R1's Face Sheet undated, indicated R1's [DIAGNOSES REDACTED]., diabetes, hypertension, and retention of urine. R1's admission Minimum Data Set ((MDS) dated [DATE], indicated R1 had a moderate cognitive impairment for decision making, sometimes was understood by others, and never or rarely understood others. The MDS indicated C1 had behaviors that did not affect others 1 to 3 days during the observation period, required extensive assistance by staff for transfers, bed mobility, and toilet use, did not ambulate during the observation period, and was always incontinent of bowel and bladder. Further, the MDS indicated C1 had balance concerns, had falls prior to admission, and had 3 falls since admission, including 1 fall with minor injuries, and 2 without injuries. C1 was documented as having no pain, but had received pain medications as needed, and had received non-medication interventions for pain. C1 had a [DIAGNOSES REDACTED]. R1's Care Area Assessment (CAA) for falls dated 4/13/20, indicated R1 had falls in the facility, and identified R1 as being at risk for further falls related to a previous stroke with residual effects. R1's CAA indicated R1 was on 15 minute checks at that time and had been receiving OT and PT 5 times weekly. R1's goal was not to be injured by a fall. R1's CAA lacked an analysis of R1's falls, and factors related to R1's falls. R1's Care Plan for safety initiated 4/1/20, and edited 6/25/20, indicated R1 was at risk for falls related to hypertension, artificial knee joints, restless leg syndrome, low potassium levels, right sided [MEDICAL CONDITION], and medications. R1's safety care plan included the following dated interventions: -4/1/20: remind to ask for assistance with activities of daily living (ADL's as needed), keep room free from clutter, and ensure a clear pathway to the bathroom and closet, ensure nonskid footwear, and keep frequently used items within reach. -4/3/20: assist to bed following supper, as R1 would try to get into bed herself. -4/6/20: call light to be within reach at all times, where she could see it, due to right-sided vision deficits. -4/20/20: place reminders in room to call for assistance, no side rails unless staff were present in the room, and low bed, which was discontinued on 4/21/20 due to R1 being able to stand up. -4/24/20: pharmacy to complete a medication review, and encourage to be at nurses desk for increased supervision, and do a 3 day bowel and bladder assessment. -5/1/20: PHQ-9 (mood assessment) to be completed, and physician medication review. -5/6/20: offer activities throughout the day to decrease boredom, with examples provided. -5/21/20, not added to care plan until 6/25/20: Leave foot of recliner down if resident is in recliner. -6/7/20, not added to care plan until 6/25/20: cabinet to be moved to the other side of the room on wall shared with bathroom. -6/13/20, added to care plan on 6/14/20, reassure resident that she did not have to pay for meals or snacks. -6/20/20, 1:1 visits to ensure safety, or to be at the nurses station In addition, R1's care plan indicated R1 had pain related to a fracture and was to be monitored for nonverbal signs of pain such as anxiety and restlessness, and report to the nurse. R1 had [MEDICAL CONDITION], and staff were directed to anticipate needs, and ask simple questions that required a yes/no response. R1's care plan interventions dated 4/21/20, directed staff to provide extensive assistance with toileting needs, and to toilet every 2 hours and as needed. R1's nursing assistant group sheet undated, indicated R1 was receiving physical and occupational therapy, used a wheelchair, required extensive assistance of one staff with transfers and toilet use, was incontinent, and was to be toileted every 2 hours and as needed. R1 had an immobilizer splint on her right arm, and was to have 1:1 visits. R1's group sheet lacked other safety interventions. R1's physical therapy discharge summary for services from 3/31/20, through 5/14/20, indicated R1 needed verbal and tactile cues to complete all tasks for safety during transfers and mobility. R1 was unable to consistently follow verbal commands. R1 was discharged from physical therapy with a restorative program. R1's fall risk assessment dated [DATE], indicated R1 had cognitive, balance, and mobility impairments. R1 received medications, and had medical conditions that increased her risk of falls, and had no orthostatic [MEDICAL CONDITION]. R1 was determined to be at risk for falls. R1 was receiving occupational and physical therapy. R1's Safety Events with Root Cause Analysis (RCA) Tool (Event Tool) completed for each fall, include a post-fall huddle within 24 hours, and the interdisciplinary team (IDT) root cause analysis. Reports for each fall include the following: -Fall dated 4/2/20, at 9:30 a.m., Event Tool completed 4/6/20. Found on floor in bedroom, unknown what R1 was doing before the fall. R1 was wearing shoes, was toileted at 7:30 a.m. and was continent when toileted and dry at time of the fall. Lack of information and communication between shift reports were determined to be a potential factor in R1's fall. The NA assigned to R1's cares had not been fully aware of her limitations with right-sided [MEDICAL CONDITION]. R1 did not have a tray table in her room and her meal tray was placed on her bed with R1 in her w/c facing the meal tray on her bed. R1 was not oriented to the location of her call light, and it should have been placed close to her on her, on her unaffected side. R1's action plan was staff education. Orthostatic blood pressures and blood glucose were not recorded on the incident report, though orthostatic blood pressures were listed on the incident report for all falls, and blood glucose checks were listed for suspected [DIAGNOSES REDACTED] in diabetics. Fall prevention program was not initiated. R1 fell on [DATE], and the RCA to identify factors and cause of fall and implement corrective action to prevent further falls, was not completed until 4/6/20. R1's progress notes dated 4/2/20, indicated R1 had a fall and staff was re-educated about orienting resident to room, proper placement of call light and tray table, and informed of resident not to be left alone for meals. -Fall on 4/3/20, at 7:20 p.m., Event Tool completed on 4/6/20. Found on the floor at bedside with no injury. R1 had been sitting in her wheelchair prior to the fall, and stated she tried to get up and walk. R1 had taken her shoes off. R1 was last toileted at 4:30 p.m. RCA by IDT on 4/6/20, indicated R1 could be impulsive and was not wearing proper footwear. R1 was incontinent of urine when found on the floor. R1's action plan indicated rearrangement of her room was suggested on 4/4/20. R1's toileting plan was not discussed. R1 fell on [DATE], and the RCA to identify factors and cause of fall and implement corrective action to prevent further falls, was not completed until 4/6/20. R1's progress notes dated 4/3/20, indicated R1 had a fall, and was assisted back into bed. R1's progress notes lacked indication of RCA and initiation of additional interventions at the time of the fall. -Fall on 4/4/20, at 7:05 p.m., Event Tool completed 4/6/20 Found on floor at bedside with no injury. R1 had been sitting in her wheelchair watching television prior to the fall. R1 had last been toileted at 3:30 p.m., was incontinent of urine at that time, and was dry at the time of the fall. R1 stated she was trying to get into bed, and had pulled the covers back on her bed. R1's IDT with RCA on 4/6/20, indicated R1 could be very impulsive and had not been toileted for 3 hours prior to the fall. R1's action plan was to place her on 15 minute checks. R1's action plan did not address R1's toileting schedule, and did not identify the care plan was not followed. R1 fell on [DATE], and the RCA to identify factors and cause of fall and implement corrective action to prevent further falls, was not completed until 4/6/20. R1's progress notes dated 4/4/20, indicated R1 had a fall, and was transferred into bed. R1's progress notes lacked

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) evidence of a staff huddle to determine RCA, and initiation of immediate interventions related to this fall. R1's progress notes dated 4/6/20, indicated an IDT review with RCA was completed on R1's falls since admission. Identification of improper footwear and improper room arrangement were identified as causal factors. 15 minute checks had been implemented with the most recent fall. -Fall on 4/9/20, at 6:00 p.m., Event Tool completed 4/10/20. R1 was found on the floor, in her room between the bed and wheelchair with no injury. R1 had been eating and watching television in her room prior to the fall. R1 had gripper socks on, had last been toileted at 5:00 p.m., and was soiled with stool at the time of the fall. R1 was unable to report what happened. R1 answered no to question about trying to go to the bathroom, but answered yes to trying to put self to bed. R1's action plan was to do a 3 day bowel and bladder. IDT follow up on 4/13/20, indicated R1 had no further falls since 4/9/20, remained on 15 minutes checks, and her walker was at the desk after being found standing by her doorway. R1's Event Tool indicated care plan was followed. R1's IDT note did not address the 3 day bowel and bladder diary. R1's progress notes dated 4/13/20, indicated and IDT review of falls with a RCA was completed and interventions were initiated as noted in the the incident report. R1's IDT review with RCA was 4 days after R1's fall. R1's progress notes dated 4/14/20, indicated R1's 14 day bowel and bladder assessment was completed and indicated R1 remained incontinent and was to be toileted every 2 hours and as needed. R1 also received scheduled pain medications three times daily and also received pain medications as requested. At that time R1 stated she had no pain, though at times had pain in her right side during transfers. -Fall on 4/15/20, at 4:25 p.m., Event Tool completed on 4/20/20. Found on floor in the resident's bathroom with no injury. R1 had last been seen sitting in her wheelchair in her room, and had last been toileted at 2:30 p.m. R1 was dry at the time of the fall, and had declined offer of toilet use prior to the fall. IDT notes from 4/20/20, indicated R1 had been making progress in therapies, but remained impulsive. She was thought to have attempted to toilet self. R1's action plan was to provide reminders in R1's room. R1's Event Tool indicated care plan was followed. R1 fell on [DATE], and the RCA to identify factors and cause of fall and implement corrective action to prevent further falls, was not completed until 4/20/20. R1's progress notes dated 4/15/20, indicated R1 had a fall, and had refused toileting prior to fall. R1 was place in the doorway of her room to monitor her more closely. R1's progress notes lacked evidence of a staff huddle to determine RCA and initiation of immediate interventions related to this fall. -Fall on 4/16/20, at 3:45 p.m., Event Tool completed on 4/20/20. R1 was found on the floor at bedside with no injury. R1 had been lying in bed prior to the fall, and had been last toileted at 1:50 p.m. R1 was dry at the time of the fall. R1's IDT with RCA on 4/20/20, indicated R1 had wanted to go to the other room at the time of the fall. R1's action plan was to implement a low bed, as R1 was unable to stand by herself. R1's Event Tool indicated care plan was followed. R1 fell on [DATE], and the RCA to identify factors and cause of fall and implement corrective action to prevent further falls, was not completed until 4/20/20. R1's progress notes dated 4/16/20, indicated R1 had a fall and had regular socks on. R1 was brought out to the nurses desk to monitor. R1's progress notes lacked evidence of a staff huddle to determine RCA and initiation of immediate interventions related to this fall. R1's progress notes dated 4/20/20, indicated an IDT with RCA review of R1's falls was completed. R1's progress notes indicated 15 minute checks continued, reminders to call for assistance and a low bed were to be added to the care plan, along with no side rails unless staff present. R1's Event Tool indicated care plan was followed. R1's IDT with RCA was done 4 and 5 days following R1's falls. R1's progress notes dated 4/22/20, indicated R1's new physician orders [REDACTED]. -Fall on 4/23/20, at 4:00 p.m., Event Tool completed on 4/27/20. R1 was found on the floor in her room with pain of the clavicle and shoulder. R1 obtained a fracture and joint dislocation of the shoulder. R1 had been watching television prior to the fall, had shoes on, and had last been toileted at 2:15 p.m. R1 had been continent of urine at the time toileted and was incontinent of stool at the time of the fall. R1 answered yes, to question regarding trying to go the bathroom. R1's IDT with RCA on 4/24/20, indicated R1 had been visualized in her room approximately 15 minutes prior to the fall, sitting in her wheelchair, watching television with her jacket on her lap. R1 stated she was attempting to self-transfer and ambulate at the time of the fall. R1's Event Tool indicated care plan was followed. Review of all falls and care plan interventions were completed at that time, and they were awaiting the results of the 3 day bowel and bladder diary. R1's action plan included consultation with provider. R1's progress notes dated 4/23/20, indicated R1 had a fall and complained of right shoulder pain. X-ray was ordered by physician, and completed. R1's progress notes dated 4/24/20, indicated a RCA was completed and included all of R1's falls since admission. R1's progress notes indicated R1 had sustained a right clavicle fracture and dislocation of right shoulder. It was noted that 4 of 7 falls were related to toileting. Care plan interventions were reviewed and included a 3 day bowel and bladder, pharmacy review of medications, 15 minute checks, encourage to be at the nursing desk for increased supervision, assistance into bed after meals, room rearrangement, and call light within reach. -Fall on 4/29/20, at 2:50 p.m., Event Tool completed on 6/26/20 Found on the floor at bedside with no injury. R1 indicated she was trying to get to her wheelchair from her bed. R1 was dry at the time of the fall. IDT with RCA was not dated. IDT note indicated R1 continued to be impulsive, was seen in the bird room after toilet use approximately 30 minutes before the fall. Resident was seen to be propelling self in wheelchair, and had received a call from family prior to the fall. At times, R1 appeared anxious and would exit seek following calls with family. Family had said they would see R1 later, and R1 was seen in her room. Staff suggested she could have self-transferred and had been trying to collect her belongings, as she had in the past. R1's Event Tool indicated care plan was followed. R1's action plan was to do a medication review. R1's progress notes dated 4/29/20, at 3:31 p.m. indicated R1 had a fall at bedside, and indicated 15 minute checks would continue. R1's progress notes lacked evidence of a staff huddle to determine RCA. -The incident report for the falls dated 4/30/20, and 5/6/20, were not provided. R1's progress notes dated 4/30/20, indicated R1 was found on the floor at 5:45 p.m. by the dining room. R1 stated she was trying to leave the facility. R1 had attempted to walk toward the clinic doors. R1's progress notes lacked evidence of a staff huddle to determine RCA and initiation of immediate interventions related to this fall. R1's progress notes dated 5/4/20, indicated and IDT review of R1's falls on 4/29/20 and 4/30/20 was completed for the initial follow up. R1 was noted to be impulsive and would be starting [MEDICATION NAME]. R1 continued to receive skilled therapies. The IDT with RCA was 4 and 5 days after R1's falls. R1's progress notes dated 5/6/20, at 8:50 p.m. indicated R1 had a fall by the side of her bed. R1 had refused to go to bed, and stated she was bored. R1 called her sister, visited with other resident, and again declined to go to bed. R1 was sitting in her wheelchair in her doorway just prior to her fall. R1's progress notes lacked evidence of a staff huddle to determine RCA and initiation of immediate interventions related to this fall. R1's progress notes dated 5/11/20, indicated and IDT review of R1's fall dated 5/6/20, was completed. R1 continued to receive skilled therapies and was impulsive with transfers and toileting due to the location of her hemorrhagic stroke. She was prescribed [MEDICATION NAME] on 5/4/20. Staff were to continue to toilet R1 every 2 hours and as needed, and place her call light within her visual field. -Fall on 5/21/20, at 10:45 a.m., Event Tool completed on 5/25/20. Found on floor in her room between recliner and nightstand with no injury. R1 had been watching TV and indicated she was trying to get into her wheelchair. R1 had shoes on, and was incontinent of urine when last toileted at 5/21/20. R1 was dry at the time of the fall. Notes indicated R1 appeared to have placed her left leg over the recliner and was reaching for the wheelchair, leading to the fall. R1's IDT with RCA on 5/25/20, indicated R1's foot pedal of the recliner was elevated, contributing to the fall. R1's action plan was for the recliner feet to remain in down position. R1's Event Tool indicated care plan was followed. R1's progress notes dated 5/21/20, indicated R1 had a fall, and lacked indication of a RCA and interventions implemented at the time of the fall. R1's fall risk assessment dated [DATE], indicated R1 had cognitive, visual, balance, and mobility impairments. R1 received medications and medical conditions that increased her risk of falls, had no orthostatic [MEDICAL CONDITION]. R1 was determined to be at risk for falls. R1's progress notes dated 5/27/20, indicated an IDT review of R1's fall on 5/21/20, with recommendations for a room evaluation, and therapy noted R1 transferred better going to her left. -Fall on 6/7/20, at 7:00 p.m., Event Tool completed 6/25/20 Found on the floor next to her bed. R1 had been sitting in her wheelchair with shoes on, and had been toileted at 6:15 p.m. when she was incontinent of urine. R1 was dry at the time of the fall. R1's IDT with RCA was not dated, though the following Monday was 6/8/20. R1's IDT note indicated R1 had refused to be assisted into bed twice, then found a few minutes after last attempt, on the floor next to her bed. R1's Event Tool indicated care plan was followed. R1's action plan was to rearrange the layout of R1's room. R1 remained continent. R1's room was evaluated and determined R1 used the cabinet for balance. The cabinet was moved away from her bed. R1's progress notes dated 6/7/20, indicated R1 had a fall, and did not include any interventions or RCA. R1's progress notes through the next week lack documentation of an RCA. -Fall on 6/13/20, at 7:00 p.m., Event Tool completed on 6/14/20. Witnessed fall next to R1's bed with no injury. R1 had gripper socks on and had been toileted at 6:30 p.m. when she was continent of urine. R1 was dry at the time of the fall. R1's IDT with RCA indicated R1 had been worried the police were going to evict her due to her medical assistance being denied. R2 was trying to transfer out of bed to attempt to leave before the authorities came to

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) evict her. R1's Event Tool indicated care plan was followed. R1's action plan was to reassure her the police would not evict her. R1's progress notes dated 6/13/20, entered on 6/15/20, indicated R1 was fearful that she could not afford to pay for her food and police would evict her. Intervention would be to reassure R1 she did not have to pay for food and beverages at meals and snacks. -Fall on 6/20/20, at 12:45 p.m., Event Tool completed on 6/25/20 R1 was found on the floor next to her bed. R1 complained of her right humerus, and was determined to have a fracture. R1 had shoes on and had been toileted previously at 11:30 a.m. R1 was dry at the time of the fall. R1 had been sent to the emergency department. An IDT with RCA dated 6/22/20, was provided. R1 had propelled self to her room, after lunch and attempted to transfer self into bed. R1 appeared to have used the radiator to help self-transfer. R1 had stated she was attempting to lay down in bed. R1 was immediately placed on 1:1 observations. R1's Event Tool indicated care plan was followed. R1's RCA notes dated 6/22/20, indicated all falls with times of falls were reviewed. With 9 falls in the afternoon, and 4 falls on the day shift and 2 on the night shift. R1 was identified as being at high risk, with factors including intermittent confusion, poor recall, poor judgement and safety awareness, poor vision, hearing deficit, balance problems, incontinent. Discussed and questioned toileting plan, effects of diuretics, antidepressant, and stimulants. Polypharmacy was discussed with previous pharmacy reviews and physician telehealth visits. Would have pharmacist do medication review, and therapy assess. R1 was unable to easily make needs known. Considered staff schedules for breaks, reporting off, and indicated nurse was to manage staffing. Consider toileting plan and work with OT on plan. Discussed activities that she liked to do, and looked at afternoon activities. R1's progress notes dated 6/20/20, indicated R1 went to the emergency department following her fall, and returned the same day with a closed [MEDICAL CONDITION] humerus. R1 was to wear a sling on right arm. 1:1 observations were initiated. R1's fall risk assessment dated [DATE], indicated R1 had cognitive, visual, balance, and mobility impairments. R1 received medications and medical conditions that increased her risk of falls, had no orthostatic [MEDICAL CONDITION]. R1 was determined to be at risk for falls. R1's progress notes dated 6/25/20, indicated an edited entry and late entry for a RCA dated 6/22/20, had been completed, noting R1 had 14 falls since admission with R1's most recent fall resulting in a right humerus fracture. R1 had been fearful of not being able to afford her room here after her medical assistance application had been declined. R1 was given free meal tickets, which decreased R1's self-transfers for a period of time. Staff explain to R1 that her family was not able to come to see her when she thinks they are going to pick her up. Redirection was attempted. A review of R1's progress notes from admission on 4/1/20, through 6/26/20, revealed R1 had several episodes of refusal of blood glucose checks and ADL cares, wandered with attempts to leave the facility, and increased confusion with impulsivity. During observations on 6/25/20, through 6/26/20, R1 was receiving 1:1 observations except during meals, when R1 ate in the dining room with one staff monitoring the dining area. In addition, other safety interventions were implemented by staff, as care planned for R1. On 6/26/20, at 12:45 p.m. R1 was wheeling away from the table after eating lunch and started wheeling down the hallway toward the large dining room. Staff came up the elevator and saw her, and returned her to the dining area, where one staff was monitoring all residents in the dining area. On 6/26/20, at 11:42 a.m. nursing assistant (NA)-C stated R1 had improved with her transfers, and transferred very well. NA-C stated they started doing 1:1's after her fall last weekend. NA-C stated they had tried different things, but she is so impulsive and quick so nothing really worked. R1 will usually tell NA-C when she has to use the bathroom and will even seek him out. NA-C stated they are told interventions in report, and when he reports to work he asks for updates when he has been off. NA-C stated safety interventions are not usually on the group sheet. On 6/26/20, at 3:18 p.m. during an interview, director of nursing (DON) stated IDT reviews with RCA of falls are done each Monday. The DON verified they were not timely identifying RCA after falls, which could potentially allow further falls and injuries related to delay in identification of root cause, and implementation of appropriate interventions. The DON reviewed each of R1's falls and RCA, and noted the following: -4/2/20: RCA- lack of communication during shift report. Information is communicated shift-to-shift in report. Nurses give report, unless it is something major and then DON will communicate it. DON stated fall interventions were usually on the group sheets, but then verified R1's group sheet still did not include all safety interventions. -4/4/20 (actually 4/3/20): RCA-R1 impulsive and not wearing proper footwear. R1 was incontinent. -4/4/20: RCA: R1 was impulsive, had not been toileted for 3 hours prior to fall. DON was not sure why they did not look at or address toileting times in the IDT meeting. DON verified toileting times should have been addressed, as R1's care plan was not followed. -4/9/20: was incontinent and self-transferred to bed. 3 day bowel and bladder was initiated with results indicating R1 was incontinent and was to be toileted every 2 hours and as needed. -4/15/20: RCA-R 1 was making progress in therapy, had proper footwear, toileting had been addressed, R1 was impulsive. Medication review was ordered and changed R1's insulin orders in that time frame. DON stated they look at vitals and blood sugars at the time of falls. -4/16/20: RCA-R1 wanted to go to another room, unable to stand independently. R1 was to have no side rails unless staff present. -4/23/20: fracture of clavicle occurred with fall. RCA-toileting needs. Initiated a 3 day bowel and bladder, medication review and initiated [MEDICATION NAME]. -4/29/20: R1 became agitated after talking to family and would get jacket and exit seek. DON talked to family. -4/30/20: R1 was agitated after talking to family, exit seeking. Social Services did a PHQ-9 mood assessment. R1 impulsive and not re-directable. Staff doing 10-15 minutes checks. When asked if something could be done to decrease agitation following family calls, DON responded that they could probably do something. -5/6/20: R1 tried to go to bed herself. Interventions included offering activities to decrease boredom. -5/21/20: RCA: R1 didn't communicate desire to get out of recliner and self-transferred. Interventions: recliner foot pedals not to be elevated. -6/7/20: R 1 was transferring self to bed, held onto bedside table and it moved. Bedside table was moved away from bed. -6/13/20: R1 was fearful of eviction after medical assistance was denied, and she thought she didn't have any money. DON stated staff thought of giving her mock free meal tickets, won in BINGO so she wasn't singled out, and it was reinforced that she didn't have to pay. -6/20/20: RCA-propelled self into room, attempted self-transfer into bed, and was trying to lay down. Interventions: 1:1's, have had meetings and not sure what else to do for R1. DON stated they would not be able to do 1:1's long term, but were working on what to do to keep her safe. At the time of the interview, the DON stated staff do a huddle after the fall to determine cause and initiate interventions, and he tries to do an RCA the next day when he comes in, but does not document reviews. The DON stated the IDT will review falls on Mondays to determine if anything else needs to be done, then reviews weekly every Monday for 4 weeks. R1's medical record lacked any evidence of a review of R1's falls by the DON. The facility policy Fall Prevention Program reviewed 1/28/20, directed the interdisciplinary team will identify appropriate interventions based on the root cause, and a pre-fall huddle would be utilized daily to discuss possible risk factors to prevent falls. The facility policy and procedure directed staff to complete an incident report and Fall RCA Tool at the point of the fall, complete a fall scene investigation to determine root cause of each fall, and include all staff present and nurse was to implement an immediate intervention to prevent a future fall. The DON was to facilitate additional action planning and IDT collaboration for action plans and report to daily huddles, quality assurance, and as needed. R3's Face Sheet undated, indicated R3 had [DIAGNOSES REDACTED]. R3's quarterly MDS dated [DATE], indicated R3 was cognitively impaired, and required extensive assist for bed mobility, dressing, and transfers. R3's care plan initiated 4/13/20, and updated 6/25/20, identified R3 as a risk for falls related to impaired mobility, history of falls, high risk medication, impaired cognition, and acting on impulse. Approaches dated 6/25/20, included offering activities after lunch, assist resident with getting out of bed in the morning when she is heard talking, when she was in bed to place her personal wheelchair next to the bed/end of bed, keep her call light within reach at all times, keep frequently used items within reach, use nonskid footwear, keep room free from clutter, make sure there is a clear path to the bathroom and to the closet, and remind R3 to ask for assistance with activities of daily living as needed. R3's interdisciplinary team (IDT) note dated 5/4/20, indicated R3 had a fall on 4/30/20, she was found on the floor in her room. No injuries noted. She was not wearing nonslip footwear. R3's IDT note dated 6/22/20, indicated R3 slid out of bed on 6/21/20, related to poor grip on yarn slipper. No injuries. Resident care plan was updated for resident not to wear yarn slippers while in bed. R3's progress note dated 6/24/20, at 1:29 p.m. indicated, Fall-(R3) was yelling out, and found lying on the floor on her back in her room. No head involvement, denies pain or discomfort. Assisted into W/C (wheelchair)with 2 staff and transfer belt. Dr notified via round book. On 6/26/20, at 10:56 a.m. R3 was observed seated in her wheelchair in her room, wearing regular white socks with gray bottoms and no shoes. -at 12:10 p.m. a staff member entered R3's room with a her meal tray. Staff did not put shoes or non-skid foot wear on R3's feet, she remained in her stocking feet. -at 12:46 p.m. R3 was observed trying to propel her wheelchair. R3 was unable to move the chair as her feet kept slipping in her stocking feet. -at 12:47 p.m. nursing assistant (NA)-D was asked to come into R3's room. NA-D verified R3 had regular socks on, and was not wearing non-skid foot wear. NA-D looked for shoes or non-skid foot wear for R3, and was unable to find any in the room. NA-D left

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	245458	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 55792

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) to look for non-skid foot wear. -at 3:23 p.m. R3 was observed wearing socks and shoes. On 6/26/20, at 2:27 p.m. the DON was interviewed. The DON stated R3 should be wearing non-skid foot wear, or some kind of grippy sock. He stated the root cause analysis for R3's fall on 6/24/20, was not completed. The DON stated the IDT meetings were held on Mondays, so the next IDT meeting would be until 6/29/20. The facility policy Fall Prevention Program dated 1/28/20, listed as a possible intervention appropriate fitting foot wear, non-skid.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure residents were not congregating for group activities or socializing while not wearing masks, and social distancing at least 6 feet apart to prevent potential exposure and spread of COVID-19. In addition, the facility failed to ensure COVID-19 symptom monitoring was completed at least daily for all residents to identify and initiate transmission-based precautions for potential symptoms of COVID-19. In addition, the facility failed to ensure the infection preventionist had sufficient dedicated time to develop, implement, and monitor an effective infection control program, and to educate staff in the implementation of infection control practices to mitigate the risks of COVID-19 and other infections for all 40 residents residing in the facility. In addition, the facility failed to ensure shared medical equipment was cleaned between use. These deficient practices had the potential to affect all 40 residents residing in the facility. Findings include: R1's Face Sheet undated, indicated R1's most recent admission was on 6/20/20, and [DIAGNOSES REDACTED]. On 6/25/20, at 10:05 a.m. registered nurse (RN)-A brought surveyors to the community lounge at the end of the east hallway. At the end of the hall, seven residents were congregated together with activity aide (AA)-A reading to them. R1 did not have a mask on, and was sitting in front of the staff who was reading, and other residents were around her. One resident had the mask on below her nose. None of the residents were re-directed to social distance or to wear masks. The activity board listed the daily activities, including hallway news at 9:45 a.m. On 6/25/20, at 12:20 p.m. the administrator stated they do group activities with residents in their doorways, but residents wander down, and they do not always wear masks. The administrator stated they have tried to get the residents to wear masks. On 6/25/20, at 1:40 p.m. the administrator stated group activities were not planned, but when they did an activity in the hallway, the residents were in their doorways, and other residents wandered down the hallway. The administrator stated it would be too disruptive to have to take residents away from the area. When asked about R1 being at group activities without a mask, the administrator stated R1 could not transport herself to the activity, and staff would have to take her there. The administrator stated there could be a risk of exposure of COVID-19 in the group setting without social distancing or masks. The administrator verified activities at the end of a hallway where residents could not social distance if they did come down was not appropriate, and increased the risk of exposure and spreading of COVID-19. Throughout the day shift and into the evening shift, several residents were in the hallways and were not wearing masks. Staff were observed to not make any attempts to social distance residents or to put masks on them, or cue them to put them on. On 6/26/20, at 10:38 a.m. AA-A sat down at the end of the east hall, reading the newspaper with residents sitting in their doorways. Staff explained to residents they must stay in their doorways and stay 6 feet apart. On 6/26/20, at 11:20 a.m. AA-A told two male residents visiting in the hallway within 6 feet of each other that they should be 6 feet apart. One backed up slightly, so were within 3 feet of each other. AA-A stated there was nothing she could do since he wouldn't move. On 6/26/20, at 11:25 a.m. the administrator stated RN-B was the infection preventionist (IP), and verified she had not had much time to spend on infection control recently, but would when the newly-hired RNs got started. The administrator stated the facility was short on RNs, so RN-B has had to work the floor. On 6/26/20, at 11:27 a.m. R1 was assisted by staff out of her room, and brought to the dining room table for lunch. R1 was wearing a mask. On 6/26/20, at 4:15 p.m. the interim director of nursing (DON) stated R1 would wear a mask at times, thought did not always want to wear a mask. The DON stated they had success with face shields for some residents for awhile. The DON stated staff would try to put masks back on residents and re-direct, but it depended on who the resident was, and who the staff was. The DON stated they would try to keep residents away from other people or bring them back to their room, rather than dealing with the resident's agitation and aggression with implementing face masks. The DON further stated the facility monitored residents for signs and symptoms of COVID-19 by doing twice daily vitals, including temperatures and oxygen saturation levels. The DON stated if there were any symptoms of COVID-19, there was a template they go through step-by-step with what symptoms to monitor for. The DON verified the facility did not document COVID-19 symptom screenings, unless they had identified a specific symptom. A review of the facility infection control logs and line lists for COVID-19 and other infections, revealed nursing assistant (NA)-A was off with a sore throat on 5/12/20, with a negative COVID-19 test and no return to work recorded. Between 5/6/20, and 5/24/20, four nursing staff were off for one day with gastro-intestinal symptoms and returned to work the following day. On 6/23/20, NA-B had a sore throat, and returned to work on 6/26/20, following a physician determination that a COVID-19 test was not needed. The facility resident illness logs and line lists for April 2020, indicated four residents had congestion and/or a cough, with no indication of quarantining or droplet precautions implemented. The facility resident illness logs and line list for May 2020, indicated three residents had episodes of nausea and vomiting, with no indication of precautions. The facility resident illness logs and line list for June 2020, indicated R1 had an elevated temp of >100 degrees Fahrenheit on 6/2/20, with a negative rapid test for COVID-19, with no other symptoms, [MEDICATION NAME] less than 24 hours. There was no indication of precautions implemented. On 6/29/20, at 9:09 a.m. RN-B stated she had very little time to work on infection control, and only had time to do the line lists and antibiotic monitoring. RN-B stated she had completed the Centers for Disease Control (CDC) infection control course in February and had been told what to do by the previous DON and a sister facility IP. IP/RN-B stated all symptoms are put on the line list or illness log, and tracked on the line list. RN-B stated staff did not stay out of work 10 days when they had potential symptoms of COVID-19. RN-B stated if staff were symptomatic, they would call the Minnesota Department of Health (MDH) COVID-19 hot line, and the provider would decide if a COVID-19 test was required, and then would have to have a three day minimum off time. RN-B stated residents who go out for routine visits wear masks while out, and upon return are brought to their room, mask removed, and screening was completed upon return. RN-B stated it was R4's right not to wear a mask outside her room. RN-B stated she did not know about the MDH toolkit which provides direction on COVID-19, and does not have enough time to review all the guidelines, so it was everyone's responsibility. RN-B stated vitals were taken for screening by NA's and if something out of the ordinary is noticed, the NA's should inform the nurses. If the vitals are abnormal, IP/RN-B is notified. IP/RN-B stated they monitor residents for symptoms just by looking at them. IP/RN-B verified there was no formal system for monitoring COVID-19 symptoms and stated NA's would not be expected to notice everything, but changes in breathing should be noticed and reported. -IP/RN-B further stated she expected staff to intervene if residents were congregating, tell them to wear masks, remind them to stay apart for safety, redirect them and try to take them to their room to give them something to do. IP/RN-B stated she would expect residents to wear masks if cognitively intact. -In addition, IP/RN-B verified shared equipment is to be cleaned after coming out of contact isolation room and whenever equipment is used for a resident. - IP/RN-B stated hand hygiene was to be completed when removing gloves, when hands are soiled, and after helping resident with a mask. -IP/RN-B stated staff are informed of changes or precautions, such as 14 day quarantines upon admission, when they listen to report at the beginning of the shift, and verified no signage was put up for new admissions, and it is not on the group sheets. -IP/RN-B stated they put COVID-19 updates in the policy book and it is reviewed weekly, but if there were any big changes, the nurses can inform the staff. Staff are not required to sign off on updates as they read them. The facility staff schedule dated 6/22/20 to 7/5/20, indicated IP/RN-B was scheduled to work from 7:00 a.m. to 8:00 p.m. as an RN on 10 of the 14 days on the two-week schedule. The schedule indicated IP/RN-B was not scheduled for dedicated time in infection control. The undated Long Term Care Prevention Infection Interim Policy for Guidance for Pandemic and Suspected or Confirmed Coronavirus (COVID-19) indicated the facility policy was to minimize exposures to respiratory diseases and identify residents with clinical symptoms and risk of COVID-19, and adhere to the federal, state, and local recommendations. The policy included direction to check for updates from the Minnesota Department of Health (MDH), Centers for Disease Control (CDC), and Centers for Medicare and Medicaid Services (CMS), since recommendations change daily. The facility policy and procedure directed there would be no group activities and residents were to be reminded to social distance, practice frequent hand washing, and wear masks if others were present. The policy and procedure further directed to implement ongoing, frequent, and active screening of residents for temperatures and respiratory symptoms. In addition, the facility policy and procedure directed hand hygiene to be completed after each resident contact and removal of personal protective equipment (PPE), and shared resident care equipment was to be cleaned and disinfected prior to use on another resident. Employees with suspected or confirmed COVID-19, were directed to not return to work until at least 3 days since

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) resolution of a fever without fever-reducing medication and improvement of respiratory symptoms, and 10 had passed since start of symptoms. The facility policy and procedure lacked guidance for management of residents who go out for appointments and return to the facility. R10's Face Sheet undated, indicated R10 [DIAGNOSES REDACTED]. R10's care plan dated 6/11/20, directed staff to ask visitors to come by the nursing station before entering R10's room to receive instruction on techniques to prevent the spread of infection to themselves or others. The care plan also indicated room arrangement isolation, semi-private room with [MEDICAL CONDITION] resident, and use principles of infection control and universal/standard precautions, Contact Isolation. R10's nursing assistant group sheet undated, indicated R10 was in contact isolation. On 6/26/20, at approximately 10 a.m. NA-B was observed exiting R10's room with a portable vital sign machine. NA-B wheeled the machine to the nurse's station and placed it next to other vital sign machines. NA-B stated he did not sanitize his hands upon leaving R10's room because he was going to wash them at the sink at the nurse's station. NA-B stated he didn't know if he was supposed to clean the vital sign machine after using it in R10's room. On 6/29/20, at 9:08 a.m. RN-B was interviewed and stated she would expect a vital sign machine that was used in an isolation room would be cleaned immediately after exiting the room. -at 10:30 a.m. RN-A was interviewed and stated he would expect residents in isolation to have their own equipment for measuring vital signs. If equipment was brought into an isolation room he would expect it to be cleaned per protocol. -at 11:12 a.m. the administrator was interviewed and stated she would expect shared equipment to be cleaned using the shared equipment protocol. The facility policy Infection Prevention and Control Manual Transmission-Based Precautions dated 2017, section Resident Care Equipment, directed staff to use disposable equipment. If the use of equipment for multiple resident is unavoidable, clean and disinfect such equipment before use on another resident. The facility policy Essentia Health Long Term Care (SNF/AL) Infection Prevention Interim Policy for Guidance during Pandemic and Suspected or Confirmed Coronavirus (COVID-19) dated 6/18/20, indicated dedicated or disposable patient-care equipment should be used. If equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to manufacture's recommendation using EPA-registered disinfectants against COVID-19.