STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING _____ B. WING _____	**08/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MINNESOTA VALLEY HEALTH CENTER INC	**621 SOUTH 4TH STREET LE SUEUR, MN 56058**

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 interview and document review, the facility failed to ensure fall risk interventions were implemented in order to minimize the risk for falls and injury for 1 of 3 (R1) residents identified at risk for falls. This deficient practice caused actual harm to R1 who utilized a remote control to raising a lift chair to the standing position, and subsequently fell sustaining bilateral femur fractures. Although the resident suffered injury, the facility immediately implemented corrective action on 7/29/20 therefore, this deficient practice is being issued as past non-compliance harm. Findings include: R1's undated Face Sheet included [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set assessment dated [DATE], included a brief interview of mental status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS also indicated R1 required extensive assistance with dressing and was totally dependent on staff for all other activities of daily living (ADLs). R1's care plan last reviewed/revised 7/8/20, indicated the resident was at a low risk for falls due to physical limitations from [MEDICAL CONDITION]([MEDICAL CONDITION]/stroke). Transfers with A-2 (assist of 2) and EZ lift (a type of mechanical lift). Able to use the call light appropriately. Can be resistive with toileting/repositioning. No recent falls. Interventions included: Unplug lift chair when in use. The Prairie Resident Care Sheets updated 8/1/20, which nursing assistants (NAs) utilized to help provide resident care, included: UNPLUG RECLINER when in use for R1. An undated Prairie List #2 sheet utilized by the NAs to refer to and write notes on also included for R1: Unplug recliner when in use. A State Agency (SA) report submitted 7/29/20, at 4:21 a.m. indicated on 7/28/20, at 11:45 p.m. R1 was using her lift chair, elevated it up resulting in her falling forward onto the ground. The report further indicated R1 was sent to the emergency room (ER) and was diagnosed with [REDACTED]. An additional report submitted to SA on 7/29/20, at 13:07 (1:07 p.m.) indicated: Writer resubmitting into appropriate system. Per (RN-A): Resident was observed on the floor in her room at 11:45 p.m. Resident was face down partially laying on right side. Resident unable to state what had happened but it was noted that her recliner chair was plugged in when it is supposed to be unplugged when resident is sitting in her chair. Resident was able to move all extremities, but appeared very painful. Resident was helped back to bed with EZ lift and three assist. Tylenol was given and ice pack applied to left knee area due to noted swelling. Resident had some bruising starting to form around her left eye. Uncertain as to where any other injury as resident unable to communicate clearly. Resident's son was informed of incident. Resident was sent to Ridgeview Le Sueur Medical Center for further evaluation. It was determined around 2:19 a.m. that resident obtained a fractured femur and was transported to Methodist Hospital in St. Louis Park. Facility cameras were reviewed by DON (director of nursing) prior to resident's fall to determine last staff members to be in resident's room. The last seen staff members in resident's room prior to fall were NAR's (NA-A) and (NA-B). DON has reached out to both NAR's to further interview and investigate situation. Resident currently has a bed hold. Action taken to protect the resident: Resident's electric lift chair removed and manual recliner placed in resident room. Education will be provided to staff regarding following resident care guides. When interviewed on 8/3/20, at 10:10 a.m. NA-B confirmed having worked the evening shift on 7/28/20, and verified having assisted with transferring R1 into her recliner after the resident's bedtime cares. NA-B confirmed at the end of his shift on 7/28/20, R1 was still in the recliner. NA-B stated, (R1) is a full assist and would not be able to self transfer or ambulate on her own, though could respond yes or no to questions. NA-B confirmed when the resident was in the recliner it was supposed to be unplugged. NA-B was unable to verify whether R1's recliner was unplugged the evening of 7/28/20, but had assumed it was unplugged because she was sitting in it. NA-B was unable to state whether R1 could use the recliner's remote control independently. When interviewed on 8/3/20, at 10:37 a.m. NA-C confirmed having worked the shift when R1 fell on [DATE]. NA-C confirmed finding R1 on the floor in her room after the fall, stating she'd been walking down the hall to answer a call light, then heard a clang and some yelling. NA-C said when she'd gone to investigate, R1 was on the floor in her room with the recliner all the way up which meant it had been plugged in, when it wasn't supposed to be. NA-C further stated, It says it right on her care plan. NA-C confirmed it was the responsibility of the staff that put the resident into the recliner to make sure it was unplugged. When interviewed on 8/3/20, at 10:48 a.m. NA-A confirmed she and NA-B had transferred R1 into her recliner the evening of 7/28/20. NA-A confirmed R1 had an electric lift chair recliner but could not confirm or deny if they had unplugged the recliner when R1 was transferred into the recliner. NA-A stated there was another resident on that unit who also needed to have their recliner unplugged while in it. NA-A stated there was one time she'd left the other resident's recliner plugged in and a co-worker had informed her the recliner needed to be unplugged when the resident was in it. NA-A stated she wasn't totally sure if R1 had the same criteria. NA-A stated she was new and on 7/28/20 had been working with another NA who was new. NA-A confirmed having training related to resident care plans, and also verified having access to resident care plans to review interventions. NA-A reported having worked at the facility for 2 months. When interviewed on 8/3/20, at 11:35 a.m. NA-D stated there was a communication binder at the nurses' desk which included the resident care sheets for NAs to refer to. NA-D confirmed when R1 was in her recliner it was to be unplugged. When interviewed on 8/3/20, at 11:50 a.m. registered nurse (RN) case manager-B confirmed R1 was to have her recliner unplugged when seated in it. RN-B stated the NA's should all know this as it is documented on the Resident Care Sheets, as well as the Prairie List sheets that the NA's have access to. RN-B stated staff are encouraged to print out and carry with those sheets with them to refer to. When interviewed on 8/3/20, at 12:40 p.m. the DON confirmed NA-A and NA-B had assisted R1 into her recliner after getting the resident ready for bed the evening of 7/28/20. The DON stated it was care planned for R1's recliner to be unplugged when the resident was in it, and stated when NA-A was interviewed during the investigation, NA-A confirmed she had put R1's remote control for the recliner on the arm of the chair after transferring the resident into the recliner. The DON Stated NA-A had confirmed she had forgotten to unplug R1's recliner. The DON stated NA's received training during their general orientation on where to find resident information. The DON also stated she'd interviewed both NA-A and NA-B related to where to find resident information and they were each able to tell her the correct answer. The DON stated staff removed the electric recliner-lift chair from R1's room following the resident's fall with fractures with a plan to replace it with a manual recliner. The hospital physician progress notes [REDACTED].o. (year old) female WC (wheelchair)/bedbound elderly female with significant post stroke deficits (nonverbal, non ambulatory, gtube dependent for nutrition) admitted early am 7/29 this am, transferred from LaSouer (sik) hospital for LEFT distal femur fracture after a fall in her NH (nursing home). CT (computed tomography scan) of the fracture here shows an incidental RIGHT distal femur fracture as well. Found to have UTI (urinary tract infection)/frankly purulent urine when catheterized. Ortho consult appreciated. This fracture has a high risk of becoming an open fracture, repair therefore required. Higher risk surgical candidate given age and comorbidities, however they are optimally manage at this time. A facility policy titled, Vulnerable Adult Abuse and Neglect Prevention Plan reviewed 4/23/20, included: Safety Measures K. The nursing home resident's Plan of Care includes and identifies any

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) areas where each individual resident is vulnerable to abuse. Functional disabilities and mental incapacities are identified as potential abuse factors. All areas of vulnerability, abuse, or neglect in the Care Plan are identified by asterisk. This procedure complies with state regulations. A facility policy titled, Fall Prevention Plan reviewed 11/2019, includes: II Care Plan A. Resident Care Plan will be developed to address implementation of fall precautions. On 7/29/20, corrective action was implemented for this deficient practice. Nursing assistants were re-educated to protocols to ensure use of the resident Care Plans, and care sheets to ensure they were aware of interventions developed for implementation to meet the individual needs of residents. The facility initiated an immediate investigation and followed up with staff determined to have been involved with R1's care prior to the fall. A revision to the resident's reclining chair was made, due to the resident's assessed risk for misuse of the electric lift recliner.