STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245370	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ECUMEN NORTH BRANCH	**5379 -383RD STREET NORTH BRANCH, MN 55056**

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 offer timely toileting assistance, in accordance with the care plan, for 1 of 3 residents (R3) reviewed for falls. This deficient practice resulted in actual harm for R3, who self-transferred to the bathroom, had a fall, and was subsequently diagnosed with [REDACTED]. Findings include: R3's Admission Record printed 7/30/20, indicated R3's [DIAGNOSES REDACTED]. R3's quarterly Minimum Data Set ((MDS) dated [DATE], identified R3 had moderately impaired cognition. The MDS further identified R3 required extensive assistance with transfers and toileting. R3 was assessed to be not steady moving on and off a toilet. R3 was occasionally incontinent of bladder and always continent of bowel. R3's care plan dated 4/11/17, indicted R3 was at risk for falls with fracture related to [MEDICAL CONDITION], and generalized weakness. The care plan further indicated R3 had a history of [REDACTED]. Interventions included anticipating and meeting the resident's needs. R3's care plan dated 4/17/17, also identified R3 had activity of daily living self-care deficits related to impaired balance and directed R3 was to be toileted every two hours and as needed. A progress note dated 1/18/20, at 10:20 p.m. indicated R3 was found lying on the floor of her bathroom. R3 was noted to be lying on her right side. R3 informed staff she was unable to remember if she was going to the toilet or coming from the toilet. R3 then informed staff she had used the toilet and was coming out of the bathroom. Staff observed toilet paper in the toilet. R3 reported right knee pain, with movement, and was unable to bear weight on her right leg. R3 was transferred to the hospital. An interdisciplinary team (IDT) progress note dated 2/6/20, at 11:40 p.m. indicated R3 had an unwitnessed fall on 1/18/20, at 9:00 p.m. in her bathroom. The IDT progress note identified R3 had a history of [REDACTED]. Staff was to offer R3 toileting every two hours and as needed. The IDT progress note revealed R3 was last offered toileting at 6:15 p.m. on 2/6/20. R3's history and physical (H&P) dated 1/19/20, indicated R3 had a history of [REDACTED]. The H&P further indicated R3 had an unwitnessed fall in her bathroom, and it was presumed R3 fell when she was getting up from the toilet to use her walker. The H&P revealed R3 was diagnosed with [REDACTED]. A document titled Ecumen North Branch Investigation Guidelines dated 1/18/20, indicated R3 was toileted at 4:15 p.m., declined to be toileted at 6:15 p.m., and was visualized in her room seated in a wheelchair at 8:00 p.m. on 8/19/20. Immediate interventions put in-place included every two hour toileting was to be followed. A document titled QAPI (quality assurance process improvement) Action Plan: Fall with Fracture 1/18/20, dated 1/22/20, revealed a root cause analysis was conducted and determined R3 fell attempting to self-transfer due to not being toileted on time. On 8/6/20, at 2:00 p.m. an interview was conducted with registered nurse (RN)-A. RN-A stated R3 was a quiet and content resident who would not go out of her way to burden anyone. RN-A stated R3 was able to use her call light, but didn't always do so. RN-A stated R3 was forgetful, was known to self-transfer to the bathroom, and was to be offered toileting every two hours. RN-A stated she was unable to remember the details of R3's fall on 1/18/20. RN-A recalled a nursing assistant (NA), who was new to long-term care, was assigned to care for R3 on the evening of the fall. RN-A confirmed it was determined R3 was not toileted timely in accordance to the care plan and R3 suffered a fracture from the fall. RN-A stated the fall was caused by time management issue. RN-A stated the facility completed audits and education after the occurrence On 8/6/20, at 2:51 p.m. an interview was conducted with the assistant director of nursing (ADON). The ADON stated she received a call from a facility nurse on 1/18/20, after R3 was found on the floor of her bathroom. The ADON stated R3 was noted to be fully clothed and had a dry incontinence product. The ADON stated staff noted toilet paper was in R3's toilet. The ADON stated she inquired when R3 was last toileted, and the nurse responded they were unsure if the resident's care plan was followed. The ADON stated R3 initially verbalized she was unable to recall what had happened, however, R3 later stated she tried to use the toilet. The ADON stated after the fall, R3 had trouble bearing weight and complained of pain. The ADON confirmed R3 was found on the floor at 9:00 p.m. and stated R3 was last toileted at 4:15 p.m. on 1/18/20. The ADON stated R3 was offered and refused toileting at 6:15 p.m. The ADON confirmed R3 was not offered toileting again after 6:15 p.m., and stated R3 was supposed to be toileted every two hours. The ADON confirmed R3's fall on 1/18/20, resulted in a pelvic fracture. The ADON stated staff were expected to re-approach a resident if toileting was refused. The ADON stated if a resident still refused assistance a nurse needed to be notified. On 8/7/20, at 11:03 a.m. an interview was conducted with the director of nursing (DON). The DON confirmed R3 was not toileted in accordance with the care plan on 1/18/20. The DON confirmed R3 was toileted at 4:15 p.m., refused toileting at 6:15 p.m., and was not offered toileting again prior to the fall on 1/18/20. The DON stated the facility standard was to notify a nurse and re-approach a resident if care was refused. The DON stated if staff were unable to be timely with cares they were expected to call for help. The DON stated the facility learned R3 suffered a fracture when the hospital was called during the night. The DON stated after the incident, all staff were educated to follow resident care plans and how to call for assistance. The DON stated education was included in orientation packets, for new hires, and was ongoing. The DON stated residents at risk for falls were reviewed and audits were completed. The DON stated staffing patterns and call light usage were also reviewed, and it was determined staffing did not contribute to the fall. The facility policy Falls - Clinical Protocol dated 9/12, directed, If interventions have been successful in preventing falling, the staff will continue with current approaches . R3 had a fall which resulted in a pelvic fracture, after a self-initiated transfer to the bathroom, as staff failed to provide toileting in accordance with the care plan. However, by 2/21/20, the facility had implemented corrective action to prevent recurrence which included a quality assurance action plan, staff education, audits, review of staffing patterns, and reviewed residents who fell frequently or were at high risk for falls.

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