STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHVIEW ACRES HEALTHCARE CENTER	**2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118**

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 follow interventions per care plan to reduce the risk for falls, for 1 of 3 residents (R1) reviewed for accidents. The facility's failure resulted in actual harm to R1 as a result of a fall from his bed to the floor, sustaining multiple fractures and was hospitalized . Although noncompliance was present at the time of the event, the facility had implemented appropriate corrective action by 7/14/20, resulting in a finding of past noncompliance at G level harm for R1. Findings Include: R1's [DIAGNOSES REDACTED]. Also, the MDS indicated R1's behaviors included wandering and he required total to extensive physical staff assistance of two staff for bed mobility, transfers, toileting and personal hygiene. In addition, the MDS indicated R1 had moderately impaired cognition, was not steady when going from sitting to standing position and required staff assistance to stabilize, and had a history of [REDACTED]. The care plan directed staff to ensure the the bed was in low position when R1 was in bed and a floor matt was at bedside when R1 was in bed. R1's progress note dated 6/17/20, at 11:00 p.m. indicated, Resident was seen crawling on the floor by Aide. Resident was awake in bed a few minutes before seen on the floor. Resident was asking writer what time it was. Aide went in the room to take care of resident when she saw him crawling towards his roommate's side. Room was well lit. Resident had no shoes on. Bed was in the lowest position. Vitals are within normal limits. Following that fall a fall risk assessment was completed on 6/17/20, which identified R1 was at high risk for falls and directed staff to follow the plan of care. During a review of R1's medical record, it was revealed on 7/8/20, at 3:13 p.m. a nursing note indicated the writer heard R1 yelling Help me! ow, ow, ow! at shift change when getting report, and when she had gone into the R1's room the writer noted that resident was lying diagonally on the floor mat on his left side, facing the doorway. The writer then indicated, Resident stated he was trying to get out of bed but no call light was activated, although it was within reach. Resident stated he had pain all over but mostly complaining of pain in his right knee. He did not rate his pain just yelled, 'ow ow ow!' His Range of Motion (ROM) was within normal limit (WNL) for him with the exception of his right knee. Neuros (neurological examination) were WNL. The on call nurse practitioner (NP) was updated and orders were obtained for as needed (PRN) [MEDICATION NAME] 5 milligram (mg) every 4 hrs, ice pack every hour for 15 min, and an X-ray to his Right knee. Also the family was updated. A review of the hospital Intake Report dated 7/13/20, indicated following R1's admission to the hospital and being seen by orthopedics, the following fractures were discovered: 1. Left proximal tibia/fibula fracture 2. Right proximal tibia/fibula fracture 3. Left first metatarsal base fracture 4. Left second metatarsal head and base fractures 5. Left third metatarsal head fracture 6. Left hallux proximal phalanx fracture During a review of the investigation/re-enactment file it was revealed upon interviews with several staff who had come to R1's room immediately after the fall when he was found on the floor, the staff had indicated they had found the bed at a high position with the floor mat where R1 was lying on. In addition, nursing assistant (NA)-A who had assisted R1 prior to the fall indicated she had lowered the bed, however, did not lower the bed all the way to the floor because R1 was eating at the time and the height was approximately about my waist length. On 7/15/20, at 4:07 p.m. family member (FM) stated, I received a call from the facility after the fall and was told he had fallen from his bed. The nurse told me they had found him on the floor matt but she did not tell me the bed was not lowered to the floor because the bed was supposed to be down as he always crawled out of bed. The nurse also told me they had started him on heavy pain medication and I did not put two and two together to think and ask myself why was he started on the medication. Then later that evening they called me again and told me he had broken his knee. FM further stated the same day he had called the facility and asked the facility staff to send R1 to the hospital where they had found R1 had multiple fractures involving multiple bones. On 7/15/20, at 12:27 p.m. during an interview with the director of nursing (DON) and administrator, both acknowledged following the review and investigation, they had identified the staff had failed to follow the care plan. Surveyor then informed the DON and administrator the multiple fractures R1 had been found to have when at the hospital and at this time the DON stated she was mortified at the amount of fractures. The DON stated following the fall, they had done an X-ray at the facility and R1 had been found to have one non-displaced [MEDICAL CONDITION] fibula which prompted the facility to send R1 to the hospital for evaluation. Although the facility failed to follow the care plan on 7/8/20, the facility was able to verify corrective action had been implemented, including NA-A receiving further education and corrective action on 7/9/20, on following the plan of care. The DON stated following the fall/incident, We have done a unit training for this particular training on following the care plan and we had a NA meeting Monday and Nurses meeting yesterday at 2:30 p.m. and talked about this. We have also done other trainings with the staff like making sure the call lights are at reach. We have audited bed heights and call lights in place and we continue to do real time education if things were out of norm and all the audits have been perfect. The DON stated the training had been done on 7/9/20, 7/13/20 and 7/14/20. The facility also completed an investigation timely. Therefore, this deficient practice is being cited at Past Noncompliance.

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.