STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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 record review the facility failed to ensure residents were free from accident hazards when a resident was transferred without following the plan of care for 1 of 3 residents (R1) who used a front wheeled walker for transfers. R1 fell during the staff assisted transfer without the use of her walker and sustained an acute left maxillary sinus fracture (a sinus located near the nose) and an acute left orbital floor (eye socket) fracture that resulted in harm. The facility had implemented corrective action so the deficient practice is being issued at past non-compliance. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], identified R1 had moderate cognitive impairment and had [DIAGNOSES REDACTED]. R1's MDS further identified she required extensive assistance with transfers, walking, bed mobility and toileting. R1's MDS identified her balance was not steady, only able to stabilize with human assistance with surface to surface transfers and from seated to standing. The MDS identified R1 had two or more falls since last assessment, and one of the falls R1 sustained a minor injury. R1's significant change of status assessment (SCSA) MDS dated [DATE], identified R1 had two or more falls since the last assessment and she acquired one major injury. R1's SCSA Care Area Assessment (CAA) dated [DATE]0/19, identified R1 had balance problems and had three falls in the last quarter of which she obtained a wrist fracture. R1's CAA identified fall interventions were in place, and she was at risk of falls related to her balance problems. Falls would be addressed in R1's care plan to maintain current level of functioning and to minimize risks. R1's care plan revised 3/5/20, identified R1 was at risk of falls, required assistance of 1 for bathing, dressing, personal hygiene and toilet use and listed various interventions which included: nursing staff to assist of 1 with FWW (front wheeled walker) for transfers. R1's care plan also directed use of chair and bed alarms, dycem and autolock breaks to wheelchair. Review of the facility incident report dated 2/28/20, identified R1 was being transferred without the use of a walker, from recliner to wheelchair when R1 lost balance and tipped forward onto the floor. R1's care plan instructed staff to transfer R1 with assistance of one with front wheeled walker, and walker was not used. The facility investigation identified nursing assistant (NA)-B was interviewed, provided education on care plan adherence regardless of familiarity and frequency of working with R1, then NA-B was sent home. R1 was sent to emergency department, and had follow up eye examination appointments on 3/2/20, 3/3/20, and 3/4/20. R1 sustained a laceration above her left eye, carpet burn to her left cheek and fracture of her left ocular cheek bone. R1's care plan was updated to include transfer assitance of 2 staff with front wheeled walker. Facility wide education was put in place for care plan adherence and safe patient handling. R1's Emergency Department Visit report dated 2/28/20, identified R1 obtained an acute left maxillary sinus fracture, an acute left orbital floor fracture and laceration related to a fall. R1 had orders for [MEDICATION NAME] (antibiotic) 500 mg orally three times a day for 5 days for [MEDICATION NAME] (preventive treatment) for sinus fracture. On [DATE], at 9:30 a.m. R1 was in her recliner with feet elevated, covered with a blanket, in her room, bedside table next to her, while she talked on the phone. At 11:01 a.m. R1 remained seated in recliner, feet on floor with one shoe on and one shoe off. At that time, registered nurse care coordinator (RNCC)-A entered room, briefly talked with R1 and proceeded to open her armoire, reviewed the care plan attached to the inside of the armoire door, then returned to assist R1 out of the recliner. RNCC-A placed R1's front wheeled walker in front of her, instructed her to push off the recliner's arm rests. R1 placed her hands on the walker, and while RNCC-A held onto R1's transfer belt, R1 stood, pivoted and then sat in wheelchair. Dycem (non-skid sheeting) was observed on the seat of the recliner, as well as an alarm pad. R1's care plan, was observed taped on the inside of R1's armoire, and instructed staff to use 1 assist with front wheeled walker for transfers. Review of R1's facility incident reports from 12/1/19, to [DATE], identified the following: -12/9/19, at 7:45 p.m. R1 found sitting on floor by bed, R1's roommate informed staff R1 had transferred self from wheelchair to bed, then slid down from the bed to the floor. R1 was reminded to call for help. -12/21/19, at 4:45 p.m. R1's bed alarm sounding, staff found R1 sitting on floor by bed. R1 informed staff she was trying to go to the bathroom, and refused to ask for assistance. R1 had been toileted twice prior that shift. -[DATE], at 4:00 p.m. R1's roommate alerted staff, who found R1 sitting on floor. R1 had self transferred herself. R1's chair alarm was found not to be properly placed. -2/28/20, at 1:29 p.m. R1 was assisted by staff with transfer from recliner to wheelchair. R1 sustained a laceration to face and had left shoulder/clavicle pain. R1's front wheeled walker was not in front of her for transfer. R1's primary care provider (PCP) was notified, and order received to send to emergency department. On [DATE], at 9:20 a.m. NA-C indicated the usual facility practice was to place individual resident care plans inside their closets. NA-C indicated if things changed, such as how a resident transfer, then RNCC-A would print off a new one. NA-C indicated she had just received training two days ago regarding care plans and to check them every day you walk into residents' rooms. On [DATE], at 10:06 a.m. trained medication aide (TMA)-A indicated she had attended training last week on care plans. TMA-A indicated staff are to make sure they check the resident's care plans in their armoires before doing anything with the residents. TMA-A indicated the nurses made changes, and we should check the dates of the care plans and if we have issues or concerns we ask the nurse. On [DATE], at 1:06 p.m. voice message was left for NA-B who returned the call on 3/11/20, at 3:31 p.m. NA-B indicated she had transferred R1 on 2/28/20, when she had her fall NA-B indicated she had not used the walker, and R1 tipped forward. NA-B indicated she had training on residents cares prior. NA-B indicated she was not aware R1 used a walker for transfers. NA-B indicated R1 wanted her to rush and get her up. NA-B indicated she was aware all residents had care plans in their closets, but had not looked before she transferred R1. NA-B indicated she had received education after the incident which included to check care plans, even if residents were in a hurry, to tell them to wait a minute while you check the care plan. On [DATE], at 1:32 p.m. NA-E indicated all residents had care plans inside their wardrobes in their rooms and she reviewed the individual resident care plans for specific instructions on how to care for the individual resident. NA-E indicated she was scheduled to attend training on care plans within the next week. On [DATE], at 1:38 p.m. NA-F indicated he had received education on how to take care of the residents. NA-F indicated he just completed care plan training again, which included [MEDICATION NAME] checking care plans to make sure you don't miss something. On [DATE], at 1:45 p.m. NA-G indicated he knew how to take care of residents based of their care plans in their closets. NA-G indicated he was aware R1 had a fall, and there was a change with her transfers. NA-G indicated when he looked at her care plan that morning, she was an assist of one staff with her walker. NA-G indicated for awhile they used two staff. NA-G was unaware if he had education or training scheduled coming up. On [DATE], at 1:49 p.m. NA-A indicated she checked residents care plans, which were taped to the inside of their closet doors to know how to provide cares to residents. NA-A indicated she also could check with her co-workers if had questions. NA-A indicated there was mandatory education for all nursing staff, today or tomorrow and it goes until 3/19/20. NA-A pointed to a sign for Mandatory Education for All Nursing Staff which included scheduled dates, posted on the cupboard above the nurses desk. On [DATE], at 1:53 p.m. RN-A confirmed mandatory education had been initiated

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) after R1's fall and indicated the mandatory in-service included a simulation regarding care plan compliance, review of abbreviations used, and a pre and post test. During the simulation sessions, RN-A indicated she observed staff and completed any additional education needed at that time. R RN-A indicated 26 nursing staff had compelted the education so far, and identified she thought there were 60 licensed and unlicensed staff who needed to complete the mandatory re-training. RN-A indicated if all staff had not completed it, the facility planned to schedule a make up day. RN-A indicated if a staff member did not complete it by then, they would be taken off the schedule until they reviewed it. RN-A indicated an announcement for the training was also texted to all staff. On [DATE], at 2:17 p.m. RNCC-A reviewed R1's electronic health record with surveyor. RNCC-A reviewed R1's history of falls, assessments of the falls and interventions put in place after the falls. RNCC-A identified R1 had five falls since 12/1/19 and indicated R1 had sustained an ocular cheek bone fracture on 2/28/20 when she fell while being assisted by a NA-B to transfer from her chair to her wheelchair. RNCC-A confirmed R1's care plan was not followed and NA-B did not use the walker with the transfer. RNCC-A indicated NA-B received individual education and the facility was in the process of completing facility wide education for all licensed and unlicensed nursing staff. On [DATE], at 2:48 p.m. licensed practical nurse (LPN)-A indicated she was scheduled to attend the mandatory training on Thursday regarding care plans. LPN-A indicated she was not aware of R1's current cares, but indicated she would need to refer to her care plan. LPN-A indicated residents' care plans were printed and placed on the inside door or resident's armoires. LPN-A indicated if there were any changes a new care plan would be put up on the inside of the resident's armoire door. On [DATE], at 3:46 p.m. in a follow up interview, RNCC-A indicated R1 had been an assist of one staff with the walker for transfers prior to her fall. RNCC-A indicated the facility had increased her to two staff with walker after the fall for a few days, then reassessed her, and returned her to assist of one staff with the walker for transfers. RNCC-A indicated they had begun to complete audits and continued to have a few going on at that time to regarding following resident care plans. RNCC-A indicated they initially completed audits with NA-B and other specific staff who had an issue with following the care plan. After that, random audits were completed on day and evening shift facility wide. RNCC-A indicated they had planned on completing a few more audits, including another one with NA-B. RNCC-A indicated if a resident had a change in their care plan, they would watch to assure staff were checking the resident's care plan. On [DATE], at 4:02 p.m. during a phone interview with family member (FM)-A, FM-A indicated she was notified the staff member transferred R1 from her chair to her wheelchair on 2/28/20, but did not have the walker in front of her, and R1's legs are not stable and that is how she fell . FM-A indicated R1 had been seen by the eye doctor and an ophthalmologist who examined her to assure her orbital muscle was still intact, and decided no surgery was needed. FM-A indicated she just wanted to be sure when staff helped R1, that they look in the armoire to read the list on how to care for R1. FM-A indicated staff should just remember to check R1's care plan in case something changed, and felt the staff should read it on a daily basis. On [DATE], at 4:07 p.m. during a follow up interview, RN-A indicated when R1 fell , R1 had blood on her hands and the carpet with staff sitting with her. RN-A indicated they got R1 up with a mechanical lift, then applied ice to her shoulder. RN-A indicated R1 had a laceration on her eyebrow and a carpet burn to her cheek. RN-A indicated R1's eye looked blood shot, but no pooling of blood in the eye was noted. RN-A indicated she contacted FM-A, then interviewed NA-B. RN-A indicated NA-B stated she forgot to check R1's care plan to see how to transfer her. RN-A indicated they completed immediate education with NA-B, and then completed audits over the weekend. On [DATE], at 4:43 p.m. during a telephone interview with R1's primary care physician (PCP)-A nurse stated the PCP would return a call tomorrow. On 3/11/20, at 8:45 a.m. PCP-A left a voice message which he indicated he would call back later that day. No further calls or messages were received. On [DATE], at 4:24 p.m. director of nursing (DON) confirmed he was aware R1's care plan was not followed as expected during a transfer and he was aware R1 had received a serious injury. The facility posting titled Mandatory Education undated, identified dates and times listed: 3/5/20, 3/12/20, or 3/19/20, at 7 a. m., 10 a.m., 2 p.m., and 4 p.m. and on 3/6/20, and 3/13/20, at 7 a.m. or 10 a.m. The form identified that one session must be attended and was a mandatory re-training session on care plans, care plan updates and transfers for all licensed nurses, trained medication aides and nursing assistants. Review of the facility Mandatory re-training session on care plans, care plan updates and transfers for all licensed nurses, trained medication aides and nursing assistants was completed. The education included a posting at all nurses stations, a written test titled Care Plan Education and Review and a simulated care plan. The signature form of those attended identified 26 licensed and unlicensed nursing staff of the 60 staff identified by the facility who required re-education, had attended through 3/6/20. Review of the facility audit forms titled Transfer Per Care Plan identified staff members were observed to determine if resident care plans were checked then followed during transfers. Seven audits had been completed by [DATE]. On spot education or resident reassessments were completed as needed. The facility policy titled Using The Care Plan revised August 2006, identified care plans were placed in the resident's chart, and care kardex were placed in the resident's closet. The policy further identified staff were responsible to provide care as directed on the resident care plan. The facility policy titled Assessing Falls And Their Causes revised October 2010, identified the purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy included areas to follow which included; after the fall, defining details of the fall, identifying causes of a fall or fall risk, documentation and reporting. The past non-compliance that began on 2/28/20, was verified during the [DATE], onsite visit and was corrected by the facility on 3/6/20. The facility immediately re-educated NA-B, other staff on that shift who worked with R1 and initiated mandatory retraining sessions for all licensed and unlicensed staff regarding care plans, care plan updates and transfers. The facility began audits to assure care plans were being followed for nursing staff through out the building. Verification of corrective action was confirmed by interview with a variety of nursing staff and documentation of chart audits that verified resident's care plans were being followed while nursing staff provided their cares. There was a plan in place for all licensed and unlicensed nursing staff to be re-educated to care plans, care plan updates and transfers. The education was reinforced by random audits still in place to ensure resident's care plans were being followed while nursing staff provided their cares.