STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHOSEN VALLEY CARE CENTER	**1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923**

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 -** Immediate jeopardy **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 safety measures were implemented for the use of the whirlpool tub for 1 of 1 resident (R1). This deficient practice was identified as past non-compliance and resulted in an immediate jeopardy for R1, who fell from the whirlpool tub and sustained sternum pain. The immediate jeopardy began 5/6/2020, when a nursing assistant was assisting R1 out of the whirlpool tub, and failed to follow manufacturer guidelines which caused R1 to fall to the floor while in the tub chair. The administrator, director of nursing, social worker and director of clinical and resident services were notified of the IJ on 5/11/2020, at 3:22 p.m. The past non-compliance immediate jeopardy was removed and the deficient practice corrected by 5/8/2020, after the facility implemented a systemic plan that included re-education of staff and competency testing with return demonstration. Findings include: During an observation and interview on 5/11/2020, at 11:35 a.m., R1 was resting in bed, no moaning or groaning noted. When interviewed at that time, R1 had no recollection of the incident. Facilities initial vulnerable adult report submitted to the state agency (SA) on 5/7/2020, at 12:00 p.m. includes, At approximately 11:45am on May 6, 2020, nursing assistant (NA-A) was assisting resident (R1) with a whirlpool bath. (NA-A) was preparing to get (R1) out of the tub. (NA-A) reports that she unbuckled the safety buckle that attaches the chair to the tub. She then opened the door to attach the chair base to the tub. (NA-A) turned to get the chair base. At that time (R1) picked up her feet which resulted in (R1) and the bath chair falling out the front of the tub. (R1) was still strapped into the bath chair by a safety belt. The chair landed upright. After (NA-A) ensured (R1's) safety she immediately notified the floor nurse, (LPN-A) Licensed Practical Nurse (LPN) who evaluated her for injuries. At that time (R1) had no observable injuries. (R1) complained of pain in sternum area and while raising her right arm. Range of motion was within normal limits. During interview on 5/11/2020, at 10:06 a.m. nursing assistant (NA)-A stated there were designated nursing assistants who are responsible for baths. NA-A indicated she may help out with bathes one time a week to fill in when needed. NA-A indicated she had one day of training with how to use the whirlpool. NA-A stated there was a safety buckle that connected the back of the tub chair to the front of the whirlpool tub. NA-A indicated she had unhooked the safety buckle from the tub chair to the whirlpool, unlatched the door at the end of the whirlpool tub and turned to get the base for the tub chair located next to the whirlpool tub. NA-A stated R1 must have kicked the whirlpool door open and slid out the end of the tub onto the floor. NA-A indicated that R1 complained of chest pain probably due to the safety belt around her waist. NA-A stated the safety belt around R1's waist was on tight during the bath and must have slid up to her chest when she slid out of the tub. NA-A stated she immediately asked if R1 was ok and called for a nurse immediately and another nursing assistant. NA-A stated this had never happened before, I just messed up. NA-A stated it was her mistake and acknowledged it and went to the director of nursing to talk to her about what had happened. NA-A confirmed the first thing that should be done was to unlock the whirlpool tub door, put the base for the chair at the end of the whirlpool bath, lock it in place and then remove the safety buckle and slide the resident forward until the chair is locked onto the base. NA-A indicated she watched a 15-minute video on proper stages of using the whirlpool after this incident occurred and return demonstrated knowledge to supervisor. R1's admission record indicated R1 was admitted to the facility on [DATE], and had [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set ((MDS) dated [DATE], included R1 had severe impaired cognition, was usually understood and understands. The MDS indicated R1 required limited assist of one staff for bed mobility, dressing, toileting and personal hygiene. The MDS further indicated R1 required supervision and set up for transfers walking in her room, the corridor and locomotion on and off the unit. R1 required bathing with physical help limited to transfer only with one-person physical assist. R1's care plan revised 12/23/2019, included, I need help with dressing and bathing. Interventions included, Give me a tub bath or shower, I typically prefer a tub bath. I need set up and supervision for bathing & transfer in/out of bath or shower with use of my walker, and supervision and set/up cues to physical assist to complete, help me as I request or need . R1's progress notes included: -5/6/2020, Called to shower room by CNA (certified nursing assistant). CNA (certified nursing assistant) had opened door to W/P (whirlpool) tub and chair with resident in it came sliding forward and landed on floor just in front of W/P (whirlpool) tub. CNA stated that safety strap was not attached. Resident complained of pain in sternum. Otherwise denied pain to extremities. ROM (range of motion) to all extremities in normal range with exception of Pain in sternum produced with raising of (R) (right) arm. No bruising or abrasions noted at this time. Action: Resident was assessed for pain and range of motion. Pain noted to sternum area. Resident noted to have good grasp B/L (bilaterally) and good ROM (range of motion) to lower extremities without pain. Resident was assisted to stand without pain and sat in chair in shower room. B/P (blood pressure) 194/81 T (temperature)-98.2, P (pulse)-60, R (respirations)-18 and 02 (oxygen) sats (saturation) 95% on room air. Resident was given [MEDICATION NAME] ([MEDICATION NAME]) (is a narcotic-like pain reliever) for sternum pain. MD (medical doctor), DON (director of nursing), SW (social worker), Case Manager, and Family notified. CNA certified educated on need to double check all safety devices in use. -5/7/2020, Resident c/o (complained of) pain and discomfort from sternum. esp (especially) with movement. When resident resting she is not having pain. Resident given PRN (as needed) [MEDICATION NAME] at 0000. Will continue to monitor. -5/7/2020, Per (medical doctor MD-A), MD: 1. Start [MEDICATION NAME] (a pain medication used to treat moderate to severe) 20mg/ml (milligrams (mg)/milliliters (ml)) give 2.5mg PO (by mouth) every 4 hour PRN (as needed) for severe pain for 7 days 2. [MEDICATION NAME] (pain medication used to treat moderate to severe) 5mg PO (by mouth) TID (three times a day) (scheduled) for 5 days 3. NP to follow up next week. 4. Monitor for any lethargy with [MEDICATION NAME] scheduled dose. 5. Discontinue aspirin. -5/8/2020, Resident c/o (complained of) sternum discomfort only when moving. Once resident is standing or sitting stationary, she does not c/o (complained of) pain. Resident will hesitate to sit because she is anticipating pain. Will continue to monitor. R1's physician telemedicine visit on 5/7/2020 included, CNA (certified nursing assistant) had opened door to W/P (whirlpool) tub. CNA (certified nursing assistant) stated that safety strap was not attached. Resident complained of pain in sternum, otherwise denied pain to extremities .She was given [MEDICATION NAME] 100 mg x1 dose without any effect. She (resident) does moan and scream with positioning. Her previous level of function was dependent with walker. I have also asked for a PT OT (physical therapy)/OT (occupational therapy) screening due to change in level of function. She does not have a bruise but is tender over sternum .She is comfort care. Family was notified and they would like us to manage her at the nursing home. During interview on 5/11/2020, at 10:22 a.m., certified nursing assistant supervisor (CNAS) said staff were in the main central bath area and explained what had happened. NA-A described unhooking the safety buckle attaching the tub chair to the front of the whirlpool prior to having the base locked in place. CNAS confirmed NA-A had not done that before. CNAS verified NA-A did not follow safety protocol; the base for the tub chair should have been locked in place before unhooking the safety buckle. CNAS stated the expectation would be to have the base in place before the whirlpool door was opened, open the whirlpool

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) door than hook the base to the chair rail and lock the brakes on the base and then go around the whirlpool and unhook the safety buckle, hold onto the arm of the chair and pull forward until the chair locks on the base. CNAS stated R1 went to her room complaining of chest pain. CNAS stated there were a few designated staff that completed bathes at the facility. CNAS indicated there had been one main bath aide but due to being overheated with wearing a mask and shield, they needed more staff to alternate giving baths. CNAS stated all staff that gave baths in the past have completed training by watching a video on the use of the whirlpool tub and completed a competency. CNAS indicated all staff would be watching the video. During follow up interview on 5/11/2020, at 11:23 a.m. CNAS indicated the competency testing included having the nursing assistant pretend to bring a resident into the whirlpool room, place the base against the rail, move the chair back into the whirlpool tub and attach the safety buckle to the tub chair, remove the base and shut the whirlpool tub door. Upon completion of the bath would first open the door, attach base and lock brakes on the base, release the safety buckle, hang onto the chair and slide it forward onto the base. During interview on 5/11/2020, at 12:23 p.m. the director of nursing (DON) verified there was nothing specific written for whirlpool training, it was part of their on the floor orientation with the nursing assistant they are training with. During interview on 5/11/2020, at 2:17 p.m. trained medication assistant (TMA)-A indicated had worked with R1 on 5/8/2020. TMA-A stated in report R1 had been complaining of pain in sternum/chest area, this was a new complaint for R1. TMA-A indicated R1 had a history of [REDACTED]. TMA-A verified R1 had been requiring [MEDICATION NAME] more often since incident. During interview on 5/11/2020, at 2:34 p.m. the DON verified NA-A had not followed protocol with equipment use pertaining to the whirlpool. DON would have expected NA-A to unlatch the safety buckle last in the steps. DON confirmed education, additional training and competency had been completed with NA-A. The Apollo Corporation Advantage TM Bathing System Operating Manual included while patient is in tub, hook chair restraint should be placed. Level Glide (Trademark) Transfer System The Level Glide Transfer System allows safe, fast, comfortable and easy transfer of virtually any resident up to 400 pounds. The chair can be used to transport the resident from their room and into the tub without intermediate transfers. Vastly superior to conventional lifts, it virtually eliminates the chances of injury to residents and caregivers The past non-compliance that began on 5/6/20, was verified during the 5/11/20, onsite visit to have been corrected by 5/8/20. Verification of corrective action was confirmed by interview with facility staff and review training documentation. The nursing assistant involved verified she was promptly re-educated on safe use of the whirlpool tub per manufacturers' guidelines. Documentation showed the facility had developed, implemented and completed a plan to assure that any nursing assistant responsible for bathing was trained. The facility also developed a plan to train those individuals who are not regularly scheduled to provide bathing. This was confirmed by review of training records and staff interview.