STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Care Center	400 Evans Avenue Elk River, MN 55330

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 to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 43367 Based on observation, interview and document review, the facility failed to provide care planned supervision to prevent falls for 1 of 3 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) situation for R1 when she sustained a right femur (leg) fracture during a fall that required surgical intervention while attempting to self-transfer unsupervised in the bathroom. The immediate jeopardy began on 5/6/24, when nurse aid (NA) assisted R1 to the bathroom, left her on the toilet, and exited the bathroom. While R1 was in the bathroom alone, she stood up and fell to her right side which resulted in a two-inch laceration to left forearm, two skin tears, two centimeters (cm), on right knee, and two skin tears above right knee. R1 rated right hip/leg pain at 8/10 (0-to-10 Pain Scale, this scale uses numbers from 0 to 10. A score of 0 means no pain, while 10 represents the worst pain a person has ever experienced) and unable to move right leg. R1 was transferred to the hospital and was diagnosed with an intertrochanteric (area located between the hip joint and the upper portion of the femur) fracture which required surgical intervention. The director of nursing (DON) and administrator were notified of the IJ on 5/15/24, at 6:40 p.m. The IJ was removed on 5/16/24, at 3:45 p.m. following verification of an acceptable removal plan however, noncompliance remained at the lower scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and no behaviors. R1 required substantial to maximal assistance for toileting hygiene and was dependent on staff to safely stand from a sitting position, and all transfers. R1 was frequently incontinent of bowel and bladder. R1's medical diagnoses included hypertension (HTN), atrial fibrillation (AFIB) (abnormal rapid heart rhythm), fracture with multiple trauma, renal failure, obstructive uropathy (flow of urine is blocked), arthritis, depression, past history of falls, and recent surgery for fracture repair. R1 received diuretics (increases urine output), anticoagulant (thins the blood), and insulin. R1's Care Area Assessment (CAA) dated 4/27/24, identified R1 had hearing and vision impairment, confusion, disorientation, forgetfulness, complications of immobility such as contractures and incontinence. R1 had functional limitation in range of motion, increased risk for falls, shortness of breath upon exertion, and history of pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's St. Louis University Mental Status (SLUMS) (detects mild cognition impairment and dementia) dated 4/23/24, identified a score of 19/30 and indicated dementia. R1's Fall Risk assessment dated [DATE], identified a fall with fracture occurred within six months prior to admission, weakness, gait impairment, and impairment of one side of lower extremity. R1's Fall Risk assessment dated [DATE], identified lack of safety and awareness due to new environment, impairment of both lower sides of extremities, wore a walking boot, weakness, and gait impairment. R1 had pre-admission fall which resulted in left foot fracture and recent fall at the facility which resulted in right hip fracture. R1 required manual stand assist (MSA) with assist of one per therapy. Staff were not to leave R1 alone unattended in bathroom. R1's care plan last updated 4/24/24, identified R1 had mobility and activities of daily living deficits due to previous left lower leg fracture, did not walk, required assist of one to stand, and transferred with walking boot on. Staff were directed to anticipate needs. R1 had a history of repeated falls. Staff were instructed to not leave R1 alone in the bathroom, fall risk. Review of R1's care plan dated 4/24/24, lacked evidence R1 preferred female care givers or was modest in the bathroom. R1's Kardex undated, identified transfer with assist of one, manual stand with walking boot. Need To Know section included: DO NOT LEAVE ALONE in Bathroom, Fall Risk!!! Resident does not walk. R1's progress note dated 5/6/2024, at 11:55 p.m. identified at 10:00 p.m. nursing assistant (NA) reported to nurse R1 had fallen on right side while she was being assisted in bathroom. R1 reported she stood up off toilet by herself and then suddenly she was on her right side. R1 sustained a two-inch laceration to left forearm actively bleeding, two skin tears two centimeters (cm) circular shape on right knee, and two circular shape skin tears above right knee. R1 rated right hip/leg pain at 8/10 and was unable to move right leg. No bruising or bleeding noted. On call triage provider notified with new orders to be sent to emergency department. R1 was hesitant to go, refused at first, but then decided was best to be seen right away. Emergency medical system (EMS) transferred R1 at approximately 11:00 p.m. to local hospital. R1's x-ray of pelvis dated 5/7/24, identified intertrochanteric (hip) fracture. R1's hospital discharge date d 5/11/24, identified principal diagnosis closed intertrochanteric (IT) fracture of the right femur with routine healing. R1 had a recent ankle fracture on 4/2/24. Per report, R1 had a witnessed fall at her nursing home facility while transferring to the toilet. R1 was on Coumadin, imagining revealed a right IT fracture, right psoas (deep within the body near the pelvis and spine) muscle and iliacus (triangle shaped muscle located in pelvic bone) muscle hematoma (an abnormal pooling of blood under the skin that resulted from broken or ruptured blood vessels). T6 and T7 and sacral fractures. R1 demonstrated profound anemia, hgb 5.2. at admission due to trauma and received three units of blood (packed red blood cells) transfusions. R1 had a right hip intramedullary (IM) (a rod placed into the hollow center of the femur/bone) surgical procedure on 5/8/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's facility incident/fall risk management report dated 5/6/24, identified R1 had been assisted to the bathroom and then fell in bathroom onto her right side. R1 sustained a right trochanter fracture, laceration of left forearm and right forearm, and skin tear of right knee. R1's hemoglobin (measures amount of oxygen carried in the red blood cells to the body's organs) 5.2 grams per deciliter (gm/dl) (normal range for woman 11.6 to 15 gm/dl) was extremely low. Contributing factor identified as NA having left R1 unattended in the bathroom, impulsivity, and history of repeated falls. Review of State Agency report dated 5/7/24, indicated on 5/6/24, at approximately 11:00 p.m. NA-A reported to licensed practical nurse (LPN)-A that R1, while being assisted in bathroom, stood up off the toilet by herself and then suddenly was on her right side. R1 had right hip/leg pain of 8/10 and unable to move leg. R1 was transferred to local hospital via EMS. Per R1's care plan and Kardex was not to be left unattended in the bathroom. Upon initial incident interview, LPN-A's perspective was R1 was not left unattended in the bathroom. On 5/7/24, at 5:00 p.m. NA-A was interviewed again by director of nursing (DON) and indicated R1 asked him to step out of the bathroom because she felt embarrassed. NA-A stepped outside the door, did not see what happened, and heard R1 fall, and quickly entered the bathroom. NA-A presumed she stood up by the sink to brush her teeth and then fell . NA-A failed to follow R1's care plan and was suspended from work until investigation was completed. NA-A stated he understood R1 was care planned to have staff stay in the bathroom with R1 as a fall intervention and it was listed on the Kardex. Review of facility investigation five-day report dated 5/13/24, identified R1's care plan was correct, up to date, and indicated staff were instructed to not leave R1 unattended in bathroom alone. NA-A admitted he left the bathroom, felt R1 was embarrassed, did not supervise through the open door. Later when NA-A was interviewed, he corrected his story indicating he brought R1 to bathroom, was asked to step out by the resident, he exited bathroom, closed door, stood outside of door and heard R1 fall onto the floor. NA-A confirmed during interview he was aware R1 was not to be left alone in bathroom. Report identified facility wide nursing education would be given. Review of a handwritten document provided by nurse manager (RN)-A on 5/15/24, identified nine staff had documented they worked directly with R1 under the cares section in PCC from 5/11/24, through 5/14/24. -5/11/24 NA-F -5/12/24 NA-G, NA-H, NA-I -5/13/24 NA-J, NA-K, NA-L -5/14/24 NA-E and NA-M Review of facility On the Spot Education on 5/15/24, revealed seven out of nine staff provided direct care for R1 and had not received the required re-education related to supervision after R1 had fallen in bathroom and fractured her right hip on 5/6/24, and prior to her return to facility on 5/11/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 5/14/24, at 9:00 a.m., R1 stated she fell at home, had surgery to repair left lower leg and shattered parts of left foot, adding, a walking boot was worn to protect the foot. R1 stated she had a fall at the facility in the bathroom not too long ago. R1 indicated she required assistance in the bathroom and was aware she was not to be left in there alone. R1 also stated she had fallen many times in bathroom prior to admission to nursing home and felt comfortable having a male in there with her. R1 indicated she did not ask NA-A to leave the bathroom the night that she fell , and she was unsure if the door was closed or open. R1 stated she informed NA-A she planned on using the toilet since she was already in the bathroom. R1 verified she stood up from toilet, in front of her wheelchair, pivoted to sit down, and then fell to the floor. R1 shared that the feeling was awful to be in the bathroom alone after the fall but once NA-A found her, he hollered for help. R1 indicated when her right leg was moved, she yelled out a lot and they took her to the hospital. During an observation on 5/14/24, at 11:05 a.m. R1 sat in wheelchair in her room. NA-D and NA-E entered R1's room and assisted her to the bathroom using the mechanical stand lift machine. NA-D and NA-E were observed to lower R1 onto the toilet and then proceeded to exit the bathroom and closed the door. NA-D and NA-E stood in the bedroom and conversed with R1's daughter for approximately seven minutes. After approximately four minutes NA-E asked R1 while door was still closed if she needed help. R1 responded no. Seven minutes had passed and then NA-E and NA-D opened the door and R1 remained sitting on toilet. Once R1 was finished using the bathroom, NA-D and NA-E assisted R1 back to her bedroom using the mechanical stand lift. During observation facility staff failed to follow care planned intervention to stay in the bathroom with R1 for safety. During interview on 5/14/24, at 2:00 p.m. NA-E stated R1's short term memory was not the best. NA-E stated R1 needed assistance of at least one in bathroom to get on and off toilet. NA-E stated prior to working with residents today she had reviewed Kardex but was unaware R1 was not to be left alone in the bathroom. NA-E stated she did not stay with R1 in the bathroom earlier today when she was in the bathroom, closed the door, and waited in the bedroom. NA-E stated had seen R1 become impulsive, get up on her own when with her. NA-E indicated would have been important to remain in the bathroom for safety to avoid falls. NA-E stated had not received education since her fall or prior to assisting her to the bathroom today. Follow up interview on 5/14/24, at 2:40 p.m. NA-E stated later today she was approached by management and read a training document, and signed to acknowledge she received the education regarding R1 who should not be left alone in bathroom. During an interview on 5/14/24, at 2:43 p.m. NA-D stated R1 required assist of one to two and a manual stand lift to transfer, depending on her strength that day. NA-D verified she had looked at R1's Kardex and transfer sheet prior to the start of the shift. NA-D stated R1 could be in the bathroom alone, with door closed but was not sure and wished the Kardex was posted in the room so that staff would know for sure. NA-D indicated she felt uncomfortable when they left R1 in the bathroom alone earlier, was not aware at that time she was not to be left alone and probably should have opened the bathroom door but chose not to and relied on the other NA. NA-D verified she had received and signed a document of On the Spot Training today, but was not sure if it was before or after R1 was transferred to and from the bathroom. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 5/14/24, at 3:39 p.m. nurse manager (RN)-A stated nursing staff were expected to help and answer resident call lights in other rooms besides those assigned to them. RN-A stated prior to each shift worked, staff were expected to read and review the resident Kardex to verify their care and how they transferred, because changes occurred frequently on the transitional care unit (TCU). RN-A stated the Kardex was considered the road map on how to care for residents and was important to know to ensure accommodation of needs and safety. During a follow up interview on 5/15/24, at 12:06 p.m. RN-A stated R1 was impulsive and a high risk for falls. RN-A verified R1 never indicated she was uncomfortable with male caregivers and, if that were the case, NA-A could have called another staff on the walkie to assist R1. RN-A indicated NA-A left R1 alone in the bathroom, she fell , and sustained a fractured right hip. RN-A verified all staff were expected to work together to verify the education was received, no date was determined to assure all staff were educated on this incident, expectation would have been prior to their next shift worked. RN-A stated it had been more than a week, a questionnaire regarding this incident was placed on a clip board at the nurse's station and staff filled them, placed them face down, and were collected periodically. RN-A verified NA-D and NA-E were educated early this morning, unsure as to what time. During an interview on 5/15/24, at 8:30 a.m. family member (FM) stated R1 was ok with having all (including male) staff in the bathroom with her because she was afraid of falling. FM also stated R1 had fallen many times and required assistance while in the bathroom. FM indicated R1 most likely would not ask staff to step out of bathroom. FM verified without a doubt R1 was very determined to go home and knew she would try to get up by herself once she could bear weight. During an interview on 5/15/24, at 8:45 a.m. physical therapist (PT) stated R1 had some cognitive deficits especially with memory. PT stated R1 was reassessed on 5/13/24, after she returned from hospital and was manual assist of one but required max assistance of two, unable to pivot. PT recommended the manual stand with one be used to assist R1. PT stated staff were expected to stay in the bathroom with R1 since she had fallen once. PT indicated R1 was not cognitively intact had already demonstrated that self-transferring leads to a fall, and now required one to two staff and the manual stand lift, to stand up. During an interview on 5/15/24, at 9:17 a.m. occupational therapist (OT) stated R1 was forgetful, distractible, impaired cognition with poor decision making and does not always stop to think about what the consequences are, and therefore was a high risk for falls. OT stated R1 required assistance with peri cares and dressing. OT stated R1 required assistance of two but always a possibility to get up by herself out of the chair especially if she had to go to the bathroom. OT stated since R1 had fallen in bathroom the expectation for staff would be stay with her in the bathroom to help minimize fall risk. OT verified R1 required transfers with the manual stand lift and assistance of one, difficult to stand up by self without assistance, but would be possible. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 5/15/24, at 10:36 a.m. director of nursing (DON) stated R1 was a high risk for falls, had at least three falls at home, admitted to nursing home with a lower leg/ankle fracture and walking boot. DON stated R1 used a wheelchair and wanted to be more independent. DON verified staff were expected to review each resident's transfers on transfer sheet, care plan, and Kardex prior to assisting them. DON also verified R1 had decreased mobility and had an intervention to not leave alone in bathroom. DON stated NA-A admitted he was aware of this intervention, R1 felt embarrassed to have him in the bathroom with her. DON stated had been identified R1 has had many falls, a fall risk, and the bathroom had hard surfaces, tile, toilet, and sink that are all very hard to fall onto and should have not been left alone in the bathroom. DON stated daily reminders were given to staff to ensure care plan interventions were being implemented and staff were expected to follow the plan of care for each resident. DON stated the floor nursing managers were responsible for education and the education for this incident needed more attention. DON indicated house wide education should have been done and was not completed in entirety and was resumed yesterday 5/14/24. DON stated all nursing staff should have received the education prior to the next day worked. During a telephone interview on 5/16/24, at 11:20 a.m. NA-A stated on 5/6/24, he answered R1's call light, she requested assistance to get ready for bed. NA-A verified he handed her a gown (night clothes) while she was in the bathroom, and asked him to step out while she changed clothes. NA-A exited the bathroom, left the door ajar (cracked open), and waited in the bedroom. NA-A indicated R1 did not want him to see her body, he encouraged independence, and once she was ready planned on assisting to bed. NA-A also stated R1 was not on the toilet rather positioned in the wheelchair in front of the bathroom sink for approximately three minutes and then shouted out for help. NA-A stated it happened all so quickly, R1 sat on the floor next to the wheelchair faced the sink and held onto the wheelchair arm with her one hand. NA-A indicated R1 had bruises on her knee and hand and notified the staff nurse right away. NA-A stated he had taken R1 to the bathroom many times such as three to four times a shift prior to this incident, cracked the door so he could hear her, and left her alone in the bathroom to provide privacy. NA-A verified was aware of R1's care plan and intervention do not leave alone in bathroom. NA-A stated R1 had tried to self-transfer in the past but privacy was important. NA-A indicated if he had been in the bathroom with her, tried to stand up he could have intervened, offered to help, and possibly prevented a fall. Facility policy titled Fall Management Protocol dated April 2024, identified all residents who were assessed as being at high risk for falls will be identified and individualized fall precautions will be developed for that resident. Preventive measures shall have been taken to decrease the number of falls whenever possible. Potential and actual risks for falls will be placed on the resident care plan along with identified individualized interventions. Facility policy titled Care Plans - Comprehensive/Baseline/discharge date d 9/2023, identified care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Facility policy titled Care Plan/Kardex Development/Use, dated 5/16/24, identified a plan of care will be developed and individualized based on comprehensive and subsequent assessments performed for each resident aimed at directing resident care/needs by all members of the interdisciplinary team. The Kardex is developed directly as a subset of the resident plan of care including specific information for the NA providing direct care to the resident. The Kardex will be reviewed daily by nursing staff prior to providing care for the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The IJ which began on 5/6/24, was removed on 5/16/24, when the facility successfully implemented a removal plan which included: All nursing staff on duty will be trained on the current Kardex/Care Plan and interventions for R1 by 12:00 p.m. on 5/16/2024. All nursing staff not on duty will be trained at the start of their next shift, prior to beginning duties on unit. All nursing staff on duty on 5/16/2024 will be trained by 12:00 p.m. on the procedures for Kardex/care plans with emphasis placed on the need to regularly and comprehensively review these documents to ensure that appropriate care is provided. Nursing staff not on duty will be trained on the same at the start of their next shift, prior to beginning duties on the unit. The policy and procedure for resident care plans has been reviewed/revised. On 5/16/24, between 9:30 a.m. and 3:30 p. m. interviews with DON, nursing staff and management verified training procedure for Kardex/care plans and need to regularly review those documents to ensure appropriate care was provided to help prevent falls. The facility had a plan in place and check off system to assure all staff would be educated prior to working their next shift.