STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245250	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Care Center	905 Elm Street Farmington, MN 55024

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** 49337 Based on interview and document review, the facility failed to implement care planned fall precautions for 1 of 3 residents (R1) reviewed for fall safety. This resulted in harm when R1 fell out of bed and sustained a fractured humerus and tibia. The facility implemented corrective action prior to the investigation, so the deficiency was issued at past noncompliance. Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 was moderately cognitively impaired, and was dependent on staff for activities of daily living (ADLs) and transfers. R1's Face Sheet dated 7/11/24, indicated R1 had diagnoses of muscle weakness, heart failure and chronic respiratory failure. R1's care plan dated 8/24/23, indicated R1 was at risk for falls, with interventions of a low bed with bedside mat. On 7/4/24 at 1:24 a.m., a progress note indicated R1 was found in her room on the floor in a sitting position, with her head leaning on the bed and her legs stretched out in front of her. R1 could not indicated what she was trying to do or how she fell but mentioned hearing children talking in her room. R1's bed was noted to be at a regular height and bed side table was pushed away from the bed. R1 had a skin tear that measured 6 centimeters by 5 centimeters. Range of motion was completed for all extremities, and R1 complained of pain to her left wrist. Pain medication was administered. R1 was returned to her bed, the bed was lowered to the floor and the floor mat was placed on the floor. R1's family and provider were notified. On 7/4/24 at 5:37 a.m., a progress note indicated licensed practical nurse (LPN)-A checked on R1 at 2:00 a. m., and completed a pain assessment. R1 was still complaining of pain, another pain medication was administered. LPN-A called R1's hospice provider to see if R1 could obtain an x-ray for concerns of a fracture. Hospice directed LPN-A to contact R1's family to see if they would like her to go to the hospital or keep her comfortable at the facility. At 2:30 a.m., LPN-A noticed R1's left leg was swollen and discolored. There was back and forth discussion with hospice and family to determine if R1 should go to the hospital while on hospice. Family decided to send R1 to the hospital and at 4:00 a.m., and 911 was called for transport to the hospital. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/4/24 at 9:58 a.m., a progress note indicated the facility was notified R1 sustained a left tibia and humerus fracture and was admitted to the hospital. On 7/6/24 at 8:03 p.m., a progress note indicated R1 was readmitted to the facility after two nights in the hospital. Her diagnosis was closed left humerus fracture of proximal end, closed fracture of proximal end of left fibula, closed fracture of proximal end of left tibia (lower leg). R1 had an arm sling and leg immobilizer. On 7/8/24 at 9:17 a.m., a progress note indicated an interdisciplinary care team reviewed R1's fall. R1 was put to bed around 7:00 p.m., and nursing assistant (NA)-A checked on R1 around 9:30 p.m., R1's incontinent brief was dry, and she appeared confused which was the baseline for R1. R1 was care planned to have a low bed with a bedside mat, and at the time of the fall her bed was not in the lowest position. NA-A was interviewed and stated she thought the bed was in the lowest position, but suggested R1 might have used the remote to elevate the bed. On 7/9/24 at 11:53 a.m., a progress note indicated R1 passed away at 11:08 a.m. On 7/11/24, an email between the director of nursing (DON) and R1's physician indicated R1's cause of death was heart failure. On 7/11/24 at 9:47 a.m., R1's family member (FM)-A stated R1 was not able to use the bed remote to control the height of the bed. The bedside mat was always in her room, and when not in use, it was placed in the corner of the room. On 7/11/24 at 11:11 a.m., NA-B stated she heard R1 yelling, and her and another staff went to R1's room. She did not see a mat in R1's room, but there used to be a mat in the room. She had never heard of R1 using the bed remote to change the bed height. R1's bed was up high when she arrived at the room. NA-B was aware that R1 required a low bed and a floor mat. On 7/11/24 at 11:30 a.m., LPN-A stated she heard someone yell for help, and found R1 sitting on the floor. R1 had a skin tear on her left shin. R1 had not had any recent falls. She did not see a mat in R1's room. R1 was able to use the bed remote, and there was a chance R1 changed the height of the bed by herself. The bed was at regular height, and not low to the floor when she entered the room. LPN-A was aware that R1's careplan indicated the bed should be in a low position and a floor mat should be in place. On 7/11/24 at 12:00 p.m., R1's primary physician (MD)-A stated R1 was known to be a fall risk because she had confusion, and would sit up at the edge of the bed occasionally. R1 had been declining prior to the fall, hospice was working on medication changes to manage her hallucinations. On 7/11/24 at 12:12 p.m., NA-A stated she put R1 to bed the night that she fell . She did not see a mat in her room during her shift. R1 could sometimes use the bed remote. She put the bed in the low position when putting R1 to bed. The nursing assistants were responsible for making sure the bed was at the correct height, and could see the care plan in the electronic health record (EHR) system. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/11/24 at 12:42 p.m., LPN-B stated she has not had issues with other staff failing to follow R1's fall interventions in the care plan. LPN-B stated the floor mat and bed position was correct when she would enter R1's room. She stated all nursing staff are responsible for making sure the bed is in a low position and the mat is placed. On 7/11/24 at 1:00 p.m., the on-call nurse manager (RN)-A was notified via phone call by LPN-A about R1's fall. R1 had started to hallucinate more frequently over the past several weeks, and thought it was related to agitation at the end of life. R1 did not have recent fall risks, but was having increased hallucinations and agitation which put her at risk for falls. She had spoken to NA-A who stated she had put the bed down in the lowest position and thought R1 had played with the bed remote. She also spoke to LPN-A, who stated the bed was in a regular position. LPN-A and NA-A had both stated the mat was not in the room when she spoke with them. On 7/11/24 at 2:57 p.m., the DON stated after the facility completed the investigation into the fall, she concluded the care plan was not followed because NA-A put the bed up at working height to check R1's incontinent brief a few hours after putting R1 to bed. NA-A forgot to lower it back down before leaving the room. LPN-A noted the bed was higher than it was supposed to be. She figured NA-A did not see the mat in the room, R1 had a lot of items in her room, and it could have been tucked away. The facility policy Fall Prevention and Management dated 2/15/24, directed a fall mitigation strategy was to complete environmental rounds. The rounds would minimize accidents by providing an environment free from hazards while keeping resident's rights in mind. The past noncompliance began on 7/4/24. The deficient practice was corrected on 7/5/24 when nursing leadership reeducated all staff. Education included expectations for rounding and lowering beds. NA-A was educated by the DON and provided a written warning. Bed height and floor mat audits were conducted for four weeks. An interdisciplinary team meeting was conducted to review R1's fall. Verification of corrective action was confirmed by observation, interview, and document review on 7/11/24.