STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Healthcare Rehabilitation and Skilled Nurs	2501 Rice Lake Road Duluth, MN 55811

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** 45842 Based on observation, interview and document review, the facility failed to ensure care plan interventions were implemented for 1 of 3 resident (R1) reviewed who required the use of a transfer belt during transfers reviewed for falls. R1 sustained actual harm when staff failed to implement the use of a transfer belt during a transfer. R1 fell , fractured multiple ribs, sustained a left sided pneumothorax (free air around lung causing some lung collapse), a left sided hemothorax (blood around the lung cause some lung collapse) that led to chest tube placement, and was sent to the emergency department (ED) requiring medical treatment. The facility implemented a corrective action prior to the survey so the deficient practice was issued at past non-compliance. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and no behaviors. R1 required partial/moderate assistance with toileting hygiene, substantial/maximal assistance with personal hygiene, upper and lower body dressing, lying to sitting on the side of the bed, sit to stand, chair/bed-to-chair and toilet transfers. R1 used a wheelchair for mobility and was occasionally incontinent of bladder and always continent of bowel. Diagnoses included fractures and other multiple trauma, cataracts, glaucoma or macular degeneration (last three are diseases that affect vision). The MDS indicated 2 or more falls in the last six months prior to admission with at least one fall causing fractures. R1's care plan, undated, identified at risk for falls due to current medical/physical status and was on medications that can/may affect fall risk. Staff were directed to keep call light positioned for easy access and to have commonly used articles within easy reach. The care plan also identified a risk and/or potential for complications with deficits with activities of daily living (ADL) related to current medical/physical status. Staff were directed to transfer with an assist of 1 using walker to transfer in and out of bed and recliner with gait belt. R1's Fall Assessment Tool dated 1/25/25 at 6:02 a.m., identified a risk for falls. R1's discharge MDS dated [DATE], identified R1 had one fall since admission with major injury. R1's progress notes from 3/5/25 through 3/6/25, identified the following: (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	-3/5/25 at 7:40 p.m., writer alerted for witnessed fall. Per nurse assistant (NA)-A was getting R1 up to use the bathroom and she had a hard time standing because R1 leans backwards. R1 stood up and turned. NA-A was holding onto R1's pants at that time and R1 fell backwards onto the ground. R1 started complaining of her back hurting. R1 stated excruciating pain in her back. Assessment completed and noted swelling upper left rib cage area that was tender to touch. R1 was Hoyer (full body mechanical lift) lift transferred to the recliner, the primary care provider was notified and orders received to send to emergency room for evaluation emergency services called and transferred R1 to the emergency room at 7:25 p.m. -3/6/25 at 3:51 p.m. follow up call to emergency department. Resident was admitted to hospital with a diagnosis of fractured ribs. R1's Emergency Department (ED) notes dated 3/5/25 at 8:30 p.m. identified chief complaint: fall. She was a [AGE] year-old female who came in after a reported fall. Patient reported she was being transferred by nursing staff and was dropped on her left side. She did not hit her head or lose consciousness. She is complaining right rib and pelvis pain. Reports she already had a couple rods placed in her hip. She stated she had left rib pain. Physical exam identified: some chest wall tenderness over the lower inferior mid axillary ribs without crepitus and no bruising. R1's computed tomography (the use of x-rays and a computer to create 3D digital images of your organs, bones, and other tissues) (CT) scan of the chest without contrast dated 3/5/25, identified a small left pneumothorax (<10% by volume of the left chest) and a small hemothorax (<10% by volume of the left chest). The CT scan also identified new minimally displace fractures of the left posterior ribs 6 through 9 and new fractures of the left transverse thoracic spine process at T7, T8, and T9. Age-indeterminate compression fractures in the thoracic spine at T3 and T9 with possible additional superior endplate deformity at T11. Critical result related to the pneumothorax and hemothorax reported to the provider. R1's hospital progress notes from 3/7/25 through 3/13/25, identified: -3/6/25 at 8:11 a.m., active problem list included closed fractures of the transverse process of thoracic vertebra, thoracic compression fracture, closed fracture of multiple ribs of left side, hemothorax with pneumothorax and fall. -3/11/25 at 9:30 a.m., hemoglobin is down to 7.2 today from 9.0 yesterday. Repeat CT scan of chest indicated a now moderate left chest hemothorax with no other signs of bleeding. Will have a chest tube placed in the left chest. -3/11/25 at 2:54 p.m., left sided chest tube placed without complication. 100 milliliters (ML) of bloody fluid sent to lab for analysis. -3/13/25 at 12:46 p.m. Chest tube still in place with 70 ML of bloody fluid out in the last 24 hours. Will keep chest tube in and continue to monitor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility investigation dated 3/5/25, identified R1 was an assist of one with walker and gait belt and had gait balance concerns. Staff were assisting R1 to the restroom when the fall occurred. She stood up but leaned back when she stood up. Staff had a hold of R1's pants when R1 fell backwards onto the floor. The investigation found that staff did not follow the care plan due to staff not using a gait belt during the transfer process. During an interview on 3/13/25 at 1:20 p.m., physical therapy assistant (PTA)-A stated R1 tended to lean backwards when she stood up and when she tried to walk. Therapy decided to keep use of the [NAME] (machine to assist resident when standing) because of the leaning backwards and her fear of falling again. PTA-A upgraded R1's transfer status to an assist of 1 staff member with walker and gait belt about two weeks prior to her fall. Nursing staff was updated that they needed to utilize the gait belt with R1 since she did have the backwards lean when she stood up and walked, which gave her an increased chance of another fall. The reason we tell nursing staff to use a gait belt is because the belt gives the staff more control of the resident and if there is a fall, the staff have better control to take the resident to the floor safely. During an interview on 3/13/25 at 1:57 p.m., registered nurse (RN)-A stated the staff were aware R1 would lean backwards when she stood up and first start to walk. Leaning backwards would increase a resident's risk of falls because of imbalance issues, which is part of the reason we told staff to make sure to utilize gait belts when they assist in transfers. RN-A stated that right after R1's fall was investigated, education was started with all nursing staff on the use of gait belts and following resident care plans. During an interview on 3/13/25 at 2:17 p.m., nursing assistant (NA)-B stated an awareness R1 would lean back when she stood up and this would increase the risk of falls. Because of leaning backwards, staff needed to use a gait belt to have better ability to assist R1 to stand and transfer safely. R1 would never rush or refuse to utilize the gait belt for transfers. We have received training in gait belt usage and care plan training since the fall occurred. During an interview on 3/13/25 at 2:43 p.m., NA-A stated it was close to the end of her shift on 3/5/24 when R1 placed her call light on. NA-A answered the call light to assist R1 to the bathroom. R1 was assisted to a standing position by holding onto R1's pants. Once R1 was standing, NA-A switched from R1's right side to her left side. R1 had leaned backwards slightly during the transfer. Before a step could be taken R1 fell backwards and fell on the floor hitting her left side of the body on the floor. NA-A stated the gait belt was not in place, but should have been prior to getting R1 out of bed. NA-A stated she received educational counseling related to gait belt usage and following the resident's care plan. During an interview on 3/13/25 at 2:48 p.m., registered nurse (RN)-B stated he was made aware of the fall when NA-A reported a witnessed fall in R1's room. When RN-B entered the room, found R1 on the floor laying on her left side. There was no gait belt around R1. RN-B performed assessment and noted R1 had a complaint of pain on the left side of the ribs and had swelling, notified the provider right away and received orders to transfer R1 to the emergency room for evaluation. After R1 was transferred to the emergency room RN-B educated NA-A on care plans because the care plan had not been followed. R1 did not have a gait belt on. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/13/26 at 2:53 p.m., the director of nursing (DON) stated R1 was supposed to have a gait belt on anytime she transferred according to her care plan. The gait belt is used to keep control and keep the resident safe when transferred anywhere. After the investigation was finished, a decision was made that the care plan was not followed since the gait belt was not utilized, which in part led to the fall. After the fall occurred and investigation was completed, staff education was started on the use of gait belts and following care plans. NA-A was educated by myself and the nurse the evening of the fall. Lastly management began audits to make sure staff would utilize gait belts and follow resident care plans. The facility gait belt policy was requested but not provided. The facility care plan policy was requested but not provided.