

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur		STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082</p> <p>Based on observation, interview and document review the facility failed to complete a thorough investigation when 1 of 1 residents (R1) alleged staff to resident abuse and the care plan was not reviewed to ensure all provisions of care were being adequately implemented. This put R1 at risk for future accidents when, during review, it was determined staff were not implementing transfer interventions as care planned.</p> <p>Findings include:</p> <p>A Facility Reported Incident (FRI) report, submitted to the State Agency (SA) on 4/30/24 at 2:00 p.m., indicated R1 had been picked up by alleged perpetrator (AP)/nursing assistant (NA-B) from the wheelchair and thrown into bed.</p> <p>A Facility Investigation 4/30/24, identified R1 reported to staff an allegation of abuse when NA-B picked her up from the wheelchair and threw her into bed. Report identified a police report was filed and, at that time, R1 denied there was abuse. AP was suspended during investigation and returned to work after education was completed on abuse. R1 was assessed by assistant director of nursing (ADON) resulting in a skin tare on elbow however, no other injuries or pain noted. Finding were identified as no abuse occurred.</p> <p>R1's significant change Minimum Data Set (MDS), dated [DATE], identified R1 was dependent with sit to stand and chair/bed-to-chair transfers and did not make efforts to complete these activities. MDS indicated R1 was diagnoses with hypertension, hyperlipidemia, hip fracture, stroke, seizure disorder, and malnutrition. R1 had a fall on 4/1/24 resulting with in a right hip fracture.</p> <p>R1's Self Care care plan, revised on 4/5/24, identified R1 was an assist of two non-weight bearing on right leg for transfers, assist of one with wheelchair, non-weight bearing on right leg, and unable to ambulate in room at this time.</p> <p>During interview on 5/1/24 at 3:29 p.m., R1 stated (NA)-B had finished her shower and took R1 back to her room in a wheelchair and NA-B told her, we are going to do this now, then NA-B placed their arms under R1's arms and dropped me in my bed. R1 stated her right inner knee had a scrape due to the placement into bed. R1 indicated she was unaware how many staff should be assisting with transfers but recalled only one staff was present during the transfer.</p> <p>(continued on next page)</p>

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur		STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 5/2/24 at 10:38 a.m., NA-B stated R1 was transferred with one staff person during the reported incident and NA-B indicated she was not aware R1 was a two-person transfer and had always transferred R1 alone. NA-B explained during the incident, R1 stood up, faced her bed and fell to the left side into the bed. NA-B was the only staff present for the transfer. NA-B also confirmed she was unaware R1 was non-weight bearing on right side due to a right hip fracture adding, floor nurses would usually update aides on changes to care plans.</p> <p>During phone call interview on 5/2/24 at 11:41 a.m., ADON stated a nurse had reported R1's concerns with NA-B which alleged she had been thrown into bed by AP. ADON stated an interview with R1 was completed along with a body check indicating no injuries except a skin tare on her elbow. ADON stated staff are to never transfer a resident under their arms and are to always use a transfer belt. ADON also stated there had been no review of R1 care plan during the investigation, so it was not determined the care plan had not been followed. Lastly, ADON confirmed there had been no re-education or competency testing with NA-B or facility care staff regarding following the care plan or safe transfers since allegation, only re-education on abuse.</p> <p>During interview on 5/2/24 at 1:06 p.m., director of nursing (DON) stated the incident had been investigated and concluded no abuse occurred. DON stated the care plan was reviewed and, I believe it was followed with two-staff assisting in transfers, however DON could not recall another aide being with NA-B during transfer.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur		STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082</p> <p>Based on observation, interview and document review the facility failed to implement Self Care plan interventions for 1 of 3 residents (R1) which put R1 at risk for falls during provisions of care.</p> <p>Findings include:</p> <p>R1's significant change Minimum Data Set (MDS), dated [DATE], identified R1 was dependent with sit to stand and chair/bed-to-chair transfers and did not make efforts to complete these activities. MDS indicated a diagnosis of hypertension, hyperlipidemia, hip fracture, stroke, seizure disorder, and malnutrition. R1 had a fall on 4/1/24 resulting in a right hip fracture.</p> <p>R1's Self Care plan, revised on 4/5/24, identified R1 was an assist of two, non-weight bearing on right leg for transfers, assist of one with wheelchair, non-weight bearing on right leg, and unable to ambulate in room at this time.</p> <p>Observations on 5/1/24 at 3:29 p.m., R1 was sitting at edge of the bed with wheelchair next to the bed. No transfer belt was observed in R1 room.</p> <p>During interview on 5/1/24 at 3:29 p.m., R1 stated NA-B had finished her shower and took R1 back to her room in a wheelchair and NA-B told her, we are going to do this now, then NA-B placed their arms under R1's arms and dropped me in my bed. R1 stated her right inner knee had a scrape due to the placement into bed. R1 indicated she was unaware how many staff should be assisting with transfers but recalled only one staff was present during the transfer.</p> <p>During interview on 5/2/24 at 10:38 a.m., NA-B stated R1 was transferred with one staff person during the reported incident. NA-B indicated she was not aware R1 was a two-person transfer and had always transferred R1 alone. NA-B also confirmed she was unaware R1 was non-weight bearing on right side due to a right hip fracture adding, floor nurses would usually update aides on changes to care plans.</p> <p>During phone call interview on 5/2/24 at 11:41 a.m., assistance director of nursing (ADON) stated a nurse had reported R1's concerns with NA-B. ADON stated an interview with R1 was completed along with a body check indicating no injuries except a skin tare on her elbow. ADON stated staff are to never transfer a resident under their arms and are to always use a transfer belt. ADON also stated there had been no review of R1's care plan during the investigation, so it was not determined the care plan had not been followed. Lastly, ADON confirmed no re-education with NA-B or facility care staff had been completed regarding following the care plan or safe transfers since the incident review, only re-education on abuse.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur		STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 5/2/24 at 12:24 p.m., nursing assistance (NA)-A stated when R1 transfers she would stand and then self-pivot to the bed. NA-A indicated a transfer belt should be used however, R1 refused most times so, I don't really ask any more. During interview NA-A reviewed R1's care plan Kardex and confirmed transfer instructions as two-person transfer assist, non-wight bearing pivot transfers. NA-A stated R1 had never been transferred with two people. NA-A further explained she had never been trained to check the care plan Kardex on the IPAD before a shift but rather nursing would tell the aides if there were changes.</p> <p>During interview on 5/2/24 at 1:06 p.m., director of nursing (DON) stated the incident had been investigated and concluded no abuse occurred. DON stated the care plan was reviewed and, I believe it was followed with two-staff assisting in transfers, however DON could not recall another aide being with NA-B during incident transfer. DON explained when there were changes in a care plan for any of the residents, there was a notice on the Kardex identifying a change and staff are to review it. DON stated aides were expected to use the IPADs to review the Kardex before each shift and staff had been trained. DON was not aware staff were not using IPADs before each shift.</p> <p>Facility policy titled Using the Care Plan, effective date 8/2021, indicated a policy statement the care plan should be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Completed care plans are located in the electronic health record. CNAs are responsible for reporting to the nurse supervisor any changes in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieve.</p>		