STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augustana Chapel View Care Center	615 Minnetonka Mills Road Hopkins, MN 55343

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview, and document review, the facility failed to comprehensively assess and discuss risks and benefits prior to installation of grab bars for 1 of 1 residents (R194) observed to have grab bars affixed to their bed. Findings include: R194's admission Minimum Data Set (MDS) indicated he had moderate cognitive impairment and required partial to moderate staff assistance with bed mobility. R194's Care Area Assessment (CAA) for cognitive loss and dementia dated 11/19/24, indicated he had observable confusion, disorientation, and forgetfulness. The CAA indicated R194 was alert and able to make his needs known. R194's CAA for falls dated 11/19/24, indicated he was a fall risk and identified risk factors including hearing impairment, cognitive impairment, pain, impaired mobility and balance, history of two falls prior to admission, and weakness post-hospitalization . A device-equipment assessment dated [DATE], indicated a left and right upper assist rail/grab bar were used. The assessment lacked indication of condition or medical symptoms(s) being addressed by the use of the devices and none of the above was checked-marked. The assessment indicated the alternative attempted but failed prior to using assist rail/grab bars was resident came on the stretcher, no other and when asked to identify the reasons for consideration of device use, the assessment indicated new admission, PT/OT to evaluate. Furthermore, the assessment indicated the device would not be considered a restraint because it was not applicable. No device to be used. The assessment lacked documentation of education provided to the resident and/or his representative and review of risks and benefits, including risk of his safety assessment and risk for entrapment. R194's care plan dated 11/15/24, indicated he required assistance with bed mobility and transferring due to impaired functional mobility and fall with low back pain. An intervention was initiated on 11/18/24, for bilateral (left and right sides) grab bars. The care plan identified other interventions of physical staff assistance of 1 with bed mobility. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 11/14/24, indicated R194's family member requested bedside rails/bars to grab when turning. The progress note lacked documentation of education or risk versus benefits provided to him or his representative. An occupational therapy evaluation and plan of treatment dated 11/15/24, with a certification period of 11/15/24 - 11/18/24, indicated he used grab bars at home prior to his admission to the facility. An occupational therapy treatment encounter note dated 11/15/24, indicated R194 was instructed to use a logroll for bed mobility to go from a flat-laying position to an upright sitting position to decrease his complaints of pain. The occupational therapy treatment encounter note lacked documentation of education provided or risks and benefits of having grab bars installed on the bed discussed. An occupational therapy treatment encounter note with a date of service of 11/18/24, and a completion date of 11/19/24, indicated R194 and his family were educated on occupational and physical therapy evaluations, plans of care and goals, however, the treatment note lacked documentation of risks and benefits of grab bars discussed. R194's physical therapy evaluation and treatment encounter notes dated 11/15/24, through 11/21/24, were reviewed on 11/21/24, and lacked documentation of education provided or risks and benefits discussed with him and/or his representatives. A care conference summary note dated 11/18/24, indicated R194 used grab bars for assistance with mobility. When asked, for any items above that resident uses, do resident and family understand the risks/benefits of the device?, the note indicated not applicable, not using any devices. R194's electronic health record (EHR) was reviewed on 11/19/24 at 2:19 p.m., and lacked documentation of education provided, risks and benefits discussed, and consent for grab bars. During observation on 11/18/24 at 1:52 p.m., the interim maintenance director (M)-A was at R194's bedside and stated he had new rails to install on his bed. During observation on 11/18/24 at 3:09 p.m., there was a left and right grab bar located on R194's bed. During interview on 11/19/24 at 2:14 p.m., registered nurse (RN)-B stated if a resident or their representative requested bed rails or grab bars for mobility, the nurse manager should be notified first. RN-B stated next, therapy would get involved for an assessment, and if the decision was made to move forward with the grab bars, a maintenance request would be made to install them. RN-B stated once maintenance had installed them, nursing staff inspect them to ensure they are safely installed. RN-B stated nursing management followed for ongoing monitoring. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/19/24 at 2:30 p.m., certified occupational therapy assistant (COTA) stated for residents requiring or requesting a bed mobility device, therapy would first evaluate and assess a resident to determine if a resident met the criteria and if there was a need for a grab bar or bedrail. Then, COTA stated if the determination was made there was a need, nursing and maintenance could get involved to have them installed. During interview on 11/19/24 at 2:37 p.m., occupational therapist (OT)-F stated indications for the use of bed mobility devices, like grab bars, could be difficulty rolling over or sitting up, or if a resident is grabbing at staff to help themselves sit up at the edge of the bed. OT-F stated therapy staff reviewed a resident's cognition and safety to ensure a resident could utilize a bed mobility device and that it would be beneficial for them to have one installed. OT-F stated therapy would send a message to nursing staff to further evaluate because they have the final say. OT-F stated staff considered a resident's history and family's preferences during their evaluations. OT-F stated during admission, there are no rails on beds so a resident could be assessed without bed mobility devices first to check into different options. OT-F stated trialed and failed alternatives are communicated with nursing staff. OT-F verified familiarity with R194 and verified an e-mail message sent to the clinical manager from therapy recommending grab bars dated 11/15/24. During interview on 11/19/24 at 2:54 p.m., licensed practical nurse (LPN)-B and transitional care unit (TCU) clinical manager stated the normal process for bed mobility devices was to have therapy evaluate a resident for mobility first. After therapy evaluated a resident, they would e-mail LPN-B their recommendations and, if in agreement, LPN-B would request a maintenance work order to have the device installed. LPN-B stated nursing staff provided education about bed mobility devices to the resident and representatives, and consent was obtained depending on what was being installed. LPN-B stated if a family member was requesting a bedrail to stop a resident from getting in or out of bed, staff would have to educate family on why they couldn't utilize a bedrail for that reason. LPN-B stated, we definitely discuss those things. LPN-B stated there was no formal process for ongoing monitoring for bed mobility devices, rather I round daily for those things. During subsequent interview on 11/20/24 at 7:26 a.m., LPN-B was not able to find documentation to support that R194 or his representatives had received education or that risks and benefits were reviewed. Furthermore, LPN-B was unable to find documentation that R194 was comprehensively assessment for safety prior to installing the grab bars. LPN-B stated there was not a formal risk versus benefits or consent in the chart. LPN-B stated it was something discussed in conversation. LPN-B stated a belief the bed mobility device assessment dated [DATE], and care conference summary dated 11/18/24, were marked in error. During interview on 11/20/24 at 12:40 p.m., physical therapist (PT)-G verified being involved in R194's care and initial assessment. PT-G stated he first attempted to logroll out of bed for mobility to mitigate the back pain, but he needed more help. PT-G stated it seemed like if he had something to pull on, like the grab bar, it might be more beneficial to him and for pain management. The logroll was the alternative intervention prior to the grab bars, and the grab bars were therapy's recommendation. PT-G stated education about the grab bars would have fallen more on the nursing staff to provide. PT-G stated therapy made recommendations and the nursing department had the final say; if nursing agreed with therapy's recommendations, they could make the request for installation. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/20/24 at 2:03 p.m., R194 stated he did not recall receiving any education on the grab bars installed on his bed. R194 stated he does not recall being told about the risks of entrapment or having discussions about his safety with grab bars on his bed. He stated the grab bars were helpful for his bed mobility and when transferring out of bed. During interview on 11/21/24 at 4:28 p.m., the interim director of nursing (DON) stated staff were expected to first assess a resident's cognitive ability to use a bed mobility device. Next, the DON expected staff to consult with therapy for an evaluation, which should be reviewed by a manager before completing a physical device assessment. The interim DON did not believe a consent was required for grab bars per the facility's policy. When asked about ongoing monitoring for bed mobility devices or equipment, the regional nurse consultant (also present during the interview), stated staff were expected to monitor with a change of condition, quarterly, and any therapy changes. Additionally, the regional nurse consultant stated staff were expected to report any change in the resident's use of grab bars to their managers so the resident could be assessed, and therapy could get involved. A facility policy titled Bed, mattress and assist rails inspection last reviewed 2/23/24, indicated prior to the installation of any side or bed rails/grab bars/assist device a physical device assessment will be conducted by the nurse with input from the interdisciplinary team (see physical device assessment policy). The physical device assessment policy was requested but not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed and appropriate personal protective equipment (PPE) was worn as required during high contact care for 2 of 3 residents (R193, R9) who required EBP and were reviewed for infection control. Findings include: R193's Minimum Data Set (MDS) dated [DATE], identified he had mild cognitive impairment and required partial-to-moderate staff assistance with toileting and personal hygiene. The MDS further indicated R193 had a bladder catheter. R193's Diagnoses Report printed 11/22/24, listed his diagnoses of bladder cancer that spread to his bone tissue, muscle weakness, malnutrition, diabetes, urinary tract infection (UTI), and artificial openings of urinary tract status-bilateral nephrostomy (nephrostomy tubes, or surgically placed catheter tubes that drain urine directly from the kidneys outside of the body into collection bags). R193's current physician orders printed 11/22/24 were reviewed and lacked documentation of the clinical indication for enhanced barrier precautions (EBP). R193's treatment administration record (TAR) printed 11/22/24, reflected the following orders: - bilateral (both sides) nephrostomy: remove dressing, cleanse site, and replace dressing, dated 11/8/24. - monitor placement for bilateral nephrostomy, dated 11/8/24. R193's care plan dated 11/8/24, indicated he required bilateral nephrostomy tubes and needed staff assistance with toileting due to his impaired functional mobility. The care plan guided staff to provide ostomy care per policy and provider orders. The care plan lacked documentation of the clinical indication for EBP. R193's electronic health record (EHR) was reviewed on 11/21/24 and it lacked clinical indication for the use of EBP. During observation on 11/18/24, there was signage on R193's door indicating he was on EBP. He was laying on his bed and a drainage bag was observed next to him at hip level. There was a scant amount of clear yellow liquid in the tubing connected to the drainage bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 11/20/24 at 8:08 a.m., licensed practical nurse (LPN)-A entered R193's room with a blood pressure machine and performed hand hygiene at the sink inside the room. LPN-A donned a pair of gloves but did not don a gown. R193 reported he was not feeling well and had stomach pain. During LPN-A's assessment, nursing assistant (NA)-A knocked and entered the room. NA-A was not wearing a gown or gloves and asked R193 about his breakfast preferences. LPN-A asked NA-A for help boosting R193 up in the bed. NA-A did not don gown or gloves and helped LPN-A boost him up in bed. NA-A used bare hands to straighten the blankets and incontinence pad on R193's bed, helped straighten his shoulders and legs before exiting the room. LPN-A continued the assessment and applied the blood pressure cuff to R193's arm, took his temporal (forehead) temperature, and placed a pulse oximeter (a device that reads the oxygen level in the blood as well as a heart rate) on his finger. LPN-A asked R193 to point to where the pain was. LPN-A palpated (an examination by touch) the area of the exposed stomach skin with the same gloved hands. LPN-A stated R193 was on EBP for his nephrostomy tube cares and staff can determine the appropriate PPE by reviewing the sign on the door. LPN-A showed the sign on R193's door, which indicated staff should wear gloves and gown for high-contact activity. When asked if the observed activities warranted PPE, LPN-A stated no because gown and gloves would only need to be worn for close contact with him, like for his catheter cares and dressing changes. LPN-A stated if other staff were unsure of the appropriate PPE for residents on EBP, they could ask other floor staff for guidance. During interview on 11/20/24 at 9:56 a.m., NA-A stated staff could tell what type of precautions and PPE were appropriate for a resident because of the signs on their doors as well. NA-A stated for EBP, staff should wear PPE when they are providing treatments or cares for the resident, physical care, incontinence cares, or if encountering bodily fluids. NA-A stated PPE would not to be worn to help transfer a resident or to help boost a resident up in bed. NA-A confirmed he did not wear PPE in R193's room and would not have been required to wear PPE for the boost because it was just a quick help. During interview on 11/21/24 at 9:48 a.m., LPN-B, also the transitional care unit (TCU) nurse manager, expected staff to wear PPE when working with a resident's wound, catheter or affected area if a resident was on EBP. LPN-B stated staff assisting a resident on EBP with a transfer or to change bed linens should be wearing PPE, but the resident was fully clothed, and nothing was exposed, then I think they would be okay without. LPN-B stated it was important to follow EBP and wear appropriate PPE because it protected the resident from infection since the resident was at a high-risk. During interview on 11/21/24 at 2:51 p.m., the director of nursing (DON) and regional nurse consultant stated staff were expected to wear gown and gloves for high contact cares when working with a resident on EBP. 51578 R9's quarterly Minimum Data Set (MDS) dated [DATE], identified a significant level of impaired cognition and a diagnosis of unidentified dementia with other behavioral disturbance, chronic respiratory failure, delirium, anxiety disorder, major depressive disorder, xerosis curtitis (severe dry skin), and unspecified fracture of the right femur in 11/22. R9 was dependent on staff for turning, repositioning, wound care, toileting, and hygiene. R9 was at a high risk for pressure ulcers and skin conditions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's provider orders dated 10/4/2024, identified EBP when providing wound care and other high contact care activities. Provider orders included wound care to the left anterior lower torso hip, left lateral foot, left lateral ankle, left medial bunion & lateral foot, right back and flank area. In addition, orders included wound care to bilateral buttock and coccyx, cover with wound cleanser, and pat dry. On 11/19/24 at 1:37 p.m., R9 was yelling to staff for help. An unidentified staff person entered R9's private room without downing a gown and applying gloves. Staff exited and donned gloves, returned to the room, and repositioned R9. The staff member was not wearing a gown. On 11/20/2024 at 7:33 a.m., NA-E entered R9's room and explained she was going to assist with morning cares. NA-E used alcohol-based hand sanitizer and applied gloves. NA-E assisted R9 to wash her face and then applied lotion to R9's arms, chest, and legs. NA-E removed gloves, washed hands with soap and water, and put on a new set of gloves. NA-E proceeded to change R9's clothing, remove R9's soiled brief, and provide perineal care. After perineal cares, NA-E removed gloves, washed hands with soap and water, put a on a new pair of gloves, and repositioned R9 in bed. NA-E did not wear a gown throughout the provision of cares, and her clothing was in contact with R9's body, clothing, and bedding multiple times. R9's hip, buttock, and coccyx wounds were observed during cares. During interview on 11/21/24 at 7:53 a.m., NA-E stated she has been trained on how and when to use PPE while caring for residents on EBP. NA-E stated she knew which residents were on EBP because they had a sign on their door and a PPE cart outside of their room. NA-E pointed to the EBP sign and PPE cart outside of R9's room. NA-E stated a gown must be worn when performing high contact cares for residents on EBP. NA-E stated R9's morning cares were considered high contact, and confirmed she should have worn a gown when providing cares. On 11/20/2024 at 9:46 a.m., infection preventionist (IP-D) stated that she trained all the staff and was responsible for initiating EBP when someone needed precautions. She explained she placed carts outside the rooms and a sign on each door of any resident that needed EBP precautions. She followed up on any additional training that was needed, conducted floor audits, and sent reminders to staff containing a list of residents on EBP. IP-D explained that she was aware that they had a high number of incidents where staff were not wearing gowns during cares with residents on EBP. IP-D stated that all staff should be wearing gloves and gown when working with residents in with EBP. If the IP-D nurse wasn't available at the time EBP precautions were needed, there was a process in place for the nurses to start EBP precautions. IP understood the importance of EBP for those residents who are in high risk of infection. A facility policy titled Transmission-based precautions and enhanced barrier precautions last revised 5/3/24 and last reviewed 7/3/24, provided examples of high-contact resident care activities requiring gown and glove use for EBP include the following: - dressing. - bathing/showering. - transferring. - providing hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- changing linens. - changing briefs or assisting with toileting. - device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. - wound care: any skin opening requiring a dressing.