

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2020
NAME OF PROVIDER OF SUPPLIER ST CRISPIN LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP 213 PIONEER ROAD RED WING, MN 55066	
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 - Minimal harm or potential for actual harm Residents Affected - Few	<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**</p> <p>Based on interview and document review the facility failed to reassess resident for transfers and failed to follow the care plan to minimize the risk for injuries and/or accidents for 1 of 3 residents (R1) reviewed for accidents. Findings include: During an interview on 6/3/2020, at 2:16 p.m. nursing assistant (NA)-A stated R1 was supposed to be transferred with two people or one person with mechanical lift. NA-A stated R1 could not stand, did not bare any weight during transfers, and she had been like that for at least 6 months. NA-A stated on 5/27/2020 she had just gotten done giving R1 her shower, and turned on the call light for help to transfer R1 into bed and after waiting for 10 minutes she decided to just transfer R1 by herself because she felt so bad for R1 as she was sitting on a hard shower chair half-dressed, was getting cold, and started getting agitated. NA-A indicated she transferred R1 to her bed to a sitting position on the edge of the bed. NA-A stated the transfer went good, and R1 was able to maintain her balance on the edge of the bed, however in the process of assisting R1 to lay down, R1 obtained a shoulder injury that required medical attention. R1's care plan dated 10/10/2018, included I have a self deficit with the following activities of daily living; bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder. I require assist of two with mechanical lift for transfers. I am non ambulatory. R1's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had moderate cognitive impairment and required extensive assistance of two or more staff members for transfers, did not walk, and had difficulty with balance. The MDS also indicated R1 did not have any functional limitations in range of motion of the lower and upper extremities. R1's activities of daily living (ADL) Care Area Assessment (CAA) dated 3/26/2020, included R1 was dependent on staff for cares related to mobility, had a [DIAGNOSES REDACTED]. The CAA also identified R1 had a right upper extremity tremor. R1's Clinical Documentation for Significant Change assessment dated [DATE], identified R1 required extensive assistance for transfers-resident involved in activity, staff provide weight bearing support with physical assistance from two or more staff members. During an interview on 6/3/2020, at 1:47 p.m. licensed practical nurse (LPN)-B stated she was the team lead for the unit that R1 resided on. LPN-B stated if NA's noticed a change in a resident's ability to transfer they should report it to the nurse, who would then assess the resident, make applicable changes to the care plan, and get an order for [REDACTED]. LPN-B said if R1 did not have the ability to bare any weight and participate in pivot transfer then a mechanical lift should be used. During an interview on 6/3/2020, at 3:30 p.m. director of nursing (DON) indicated an awareness NA-A had not followed R1's care plan for transfers and would expect all staff to follow the care plan, and failure to do so could result in serious injury to the resident. DON provided a call light audit report and confirmed R1's call light had been sounding for just over 9 minutes, and would have expected that NA-A not complete the transfer and wait for assistance. DON confirmed the last time R1 was evaluated and treated by therapy was in November of 2018, and was not aware that R1 had, had a decline in her ability to transfer. DON indicated staff should notify the doctor and obtain order for a physical therapy evaluation. DON indicated staff should not be pivot transferring residents who do not have the ability to bare weight and staff should not have been completing transfers by lifting them up and moving them. During an interview on 6/3/2020, at 3:52 p.m. physical therapist (PT), confirmed R1 has not been evaluated and/or treated since November of 2018 at which time R1 could stand and bare some weight. PT indicated an unawareness R1 was no longer bearing weight and staff were essentially lifting her during transfers. PT stated if R1 was not bearing weight or did not have the ability to, staff should not do pivot transfers or use the standing lift; R1 should not be hanging in the machine, so a full body mechanical lift should be used for R1's and staff's safety. PT stated when residents have a decline in mobility staff should obtain a physician order [REDACTED]. 6) The assessment must include at least the following, I. physical functioning and structural problems. 8) Assessment process must include direct observation .11) All person centered care plan interventions will be implemented by qualified personnel. Facility Wheelchair Transfer (Two-Person) Critical Step Skill dated 2009, outlined the procedure for two person transfer and directed the following: 6) Apply transfer belt around resident's waist. 8) Both caregivers go to the position of strength: Stand closer to either side of the resident; place your arm nearest the resident, on the transfer belt under the arm; support the resident's back with opposite arm. 10) Lift resident to standing position. Support with transfer belt with an underhand grasp and change position only by moving your feet.</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

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.