DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: NJ39

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00668

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245564**
2.STATE VENDOR OR MEDICAID NO.
(L2) **990343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BROWNS VALLEY HEALTH CENTER**
(L4) **114 JEFFERSON STREET SOUTH**
(L5) **BROWNS VALLEY, MN** (L6) **56219**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/14/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **41** (L18)
13.Total Certified Beds **41** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	41			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE - NE II 11/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcment Specialist 11/29/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/28/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On September 18, 2017 through September 20, 2017 a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR 483, Subpart B, and requirements for Long Term Care Facilities.

On September 21, 2017 and September 22, 2017 an extended survey was completed at this facility. The most serious deficiency (F323) was cited at a S/S level of J. Conditions in the facility at the time of the survey constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health and safety. The IJ began on June 12, 2017. The Administrator and DON were notified of the IJ on September 21, 2017 at 11:09 a.m. The IJ was abated on September 22, 2017 at 3:39 p.m., however non-compliance remained at a lower S/S level of G. Post Certification Revisit to follow.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245564 November 29, 2017

Ms. Autumn Roark, Administrator
Browns Valley Health Center
114 Jefferson Street South
Browns Valley, MN 56219

Dear Ms. Roark:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 27, 2017 the above facility is recommended for:

41 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 41 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 29, 2017

Ms. Autumn Roark, Administrator
Browns Valley Health Center
114 Jefferson Street South
Browns Valley, MN 56219

RE: Project Number S5564027

Dear Ms. Roark:

On October 4, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 9, 2017. (42 CFR 488.422)

Also on October 4, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on September 22, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On November 14, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 27, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on September 22, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 27, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on September 22, 2017, as of October 27, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 27, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedy outlined in our letter of October 4, 2017.

- Civil money penalty for deficiency sited at F323, be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 29, 2017

Ms. Autumn Roark, Administrator
Browns Valley Health Center
114 Jefferson Street South
Browns Valley, MN 56219

Re: Reinspection Results - Project Number S5564027

Dear Ms. Roark:

On November 14, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 22, 2017, with orders received by you on October 4, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NJ39

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00668

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245564**

2.STATE VENDOR OR MEDICAID NO.
(L2) **990343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BROWNS VALLEY HEALTH CENTER**
(L4) **114 JEFFERSON STREET SOUTH**
(L5) **BROWNS VALLEY, MN** (L6) **56219**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/22/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **41** (L18)

13.Total Certified Beds **41** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	41			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 10/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/21/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On September 18, 2017 through September 20, 2017 a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR 483, Subpart B, and requirements for Long Term Care Facilities.

On September 21, 2017 and September 22, 2017 an extended survey was completed at this facility. The most serious deficiency (F323) was cited at a S/S level of J. Conditions in the facility at the time of the survey constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health and safety. The IJ began on June 12, 2017. The Administrator and DON were notified of the IJ on September 21, 2017 at 11:09 a.m. The IJ was abated on September 22, 2017 at 3:39 p.m., however non-compliance remained at a lower S/S level of G. Post Certification Revisit to follow.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 4, 2017

Ms. Autumn Roark, Administrator
Browns Valley Health Center
114 Jefferson Street South
Browns Valley, MN 56219

RE: Project Number S5564027

Dear Ms. Roark:

On September 22, 2017, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on September 22, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective October 9, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Browns Valley Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 22, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care, which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 22, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245564	A. BUILDING _____ B. WING _____	09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNS VALLEY HEALTH CENTER	114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on September 18, 19, 20, 21 and 22, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F323 when R29 had not been comprehensively assessed for the root cause of repeated attempts of self transfer and appropriate interventions implement. This practice resulted in a risk for serious harm, injury or death. The IJ began on 6/12/17 and was removed on September 22, 2017, at 3:39 p.m. As a result of identifying substandard quality of care, an extended survey was conducted on September 21 and 22, 2017. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect,	F 225		10/27/17

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

Electronically Signed | 10/11/2017

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.

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	245564	A. BUILDING _____ B. WING _____	09/22/2017

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F 225	Continued From page 1 exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 225		

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F 225	Continued From page 2 procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report injuries of unknown source and potential neglect of care to the State agency for 1 of 3 (R29) residents reviewed for abuse/neglect/neglect of care. R29 sustained an injury of unknown source that was not reported within 24 hours, and then when staff became aware of a fracture failed to report within 2 hours. R29 also sustained a fractured hip following a fall where fall interventions were not in place, and the facility failed to report potential neglect of care within 2 hours when aware of the fracture. In addition, the facility failed to implement policy for completion of a thorough investigation for 1 of 1 resident (R29) reviewed with a injury of unknown origin with serious bodily injury. Findings Include: Review of R29's signed Physician Order Sheet, signed 9/5/17, identified diagnoses which	F 225	F225 Browns Valley Health Center will report all injuries of unknown origin and potential neglect of care to the State Agency. The facility completed a thorough investigation of R29 injury of unknown origin dated 6/12/17 on 10/10/17. All residents have the potential to be impacted by a deficient practice in this area. The facility's Maltreatment Policy reporting guidelines were reviewed and revised on 9/30/17. All Charge Nurse staff will be re-educated on the process of reporting any injuries to Administrator, DON, or on-call RN. All designated State Agency reporters will be re-educated on the care center's Malpractice Policy and the reporting guidelines. Education will be done via the Nurse's meeting which will be held on 10/25/17.	

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F 225	Continued From page 3 included dementia with behavioral disturbance, chronic obstructive pulmonary disease and recurrent major depression. R29's quarterly Minimum Data Set (MDS) dated 6/6/17, identified R29 had diagnoses which included dementia, osteoporosis and depression. The MDS listed R29 had severe cognitive impairment, and required extensive assistance with dressing, hygiene, toileting, transfers and locomotion. Further, the MDS identified R29 had a fall since the prior assessment. R29's significant change MDS dated 8/31/17, identified R29 had severe cognitive impairment, required extensive assistance with dressing, hygiene, eating and locomotion, total assistance with transfers, toileting and did not walk. R29's current care plan printed on 9/20/17, at 3:04 p.m. last updated 8/21/17, at 3:23 p.m. by registered nurse (RN)-A identified R29 had a potential for abuse. The care plan also indicated R29 was at risk for falls or injury related to cognitive deficits and required assistance with activities of daily living (ADL)s. The care plan further indicated R29 did not remember that she needed assistance with transfer or ambulation, and instructed staff to anticipate her needs. Review of R29's Incident Details/Fall Scene Investigation Report from 6/12/17, revealed the following: -6/12/17, at 8:00 a.m. during a.m. cares R29 was disorientated, and complained of discomfort in her right shoulder with movement. A bruise on the top of her right clavicle region was noted, with swelling around the site. A scrape below her right	F 225	All incidents will be audited by DON/designee to ensure a thorough investigation is completed to identify origin and the care plan is updated with new interventions. Audits will be done 4x week for 2 weeks, then 2x week for 2 weeks, then weekly. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The auditing results will be reported monthly to the Performance Review team on 10/19/17 and quarterly to the full QAPI team on 11/14/17. The QAPI team will make recommendations for ongoing monitoring. Completion date for F225 is Oct. 27th, 2017	

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F 225	Continued From page 4	F 225		

knee was also noted. R29 winced with discomfort with movement of the area. The report indicated R29 reported, "I fell" and denied any assistance after the fall. The report listed staff were to use 2 for all transfers with a gait belt until after the portable x-ray was completed. The report indicated a portable x-ray done identified a fracture of her distal right clavicle. The record included written statements from staff dated which noted R29 had been assisted to bed at approximately 6:30 p.m. on 6/11/17, and had no visible bruises and no complaints of pain at that time. The staff statement indicated 5:00 a.m. rounds had been completed on 6/12/17, and she was sleeping at that time and no complaints of pain. A staff written statement dated 6/13/17, indicated the staff member had assisted R29 with morning cares on 6/12/17. The statement indicated during cares, R29 had indicated her arm hurt and staff found bruises on her shoulder and front of her right leg. The record also included written statements from 6/13/17, which indicated R29's bed had been unable to be put in low position a week prior and maintenance personnel had been notified of the broken bed. Maintenance had determined new parts for the bed needed to be ordered, and adjusted the bed to the lowest position, and would remain in that position until the new part installed. The written statement from maintenance personnel dated 6/13/17, indicated he had set the bed in approximately 3 inches higher than the lowest position possible, ordered the needed parts for the bed and installed the parts on 6/13/17. An IDT meeting note dated 6/13/17, indicated R29 had been noted to have bruising and complaints of pain in her right shoulder during morning cares. The note indicated staff had asked R29 what happened and she had stated she fell and

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nobody had helped her get up. R29's care plan was revised to include 2 assist for transfers at that time. No documentation of further investigation of the cause of R29's injury was noted, no further analysis of the effectiveness/use or function of the safety devices in place had been completed.

Review of R29's progress notes revealed the following:

-6/12/17, at 8:15 a.m. R29 grabbed and squeezed right shoulder winced and complained of pain. R29 had a bruise on top of her right clavicle region, swelling was noted around the site. A scrape was noted also below R 29's right knee. R29 stated she fell when asked, and when asked if anyone helped her she shook her head no. R29's primary physician was notified and orders were received for a PPX (portable x-ray). Two staff assistance for R29 with all transfers and transfer belt until PPX completed.

-6/12/17, at 7:59 p.m. results of x-ray indicated fracture of distal right clavicle. R29's primary physician was notified.

Review of submission to Office of Health Facility Complaints (OHFC) identified the report had been submitted on 6/13/17, at 1:07 p.m.

Review of R29's investigation summary of the 6/12/17, incident revealed on 6/12/17, during a.m. cares NAR (nursing assistant registered) staff indicated R29 complained of pain in her right shoulder area and noted a bruise and swelling at the top of the right clavicle region. When asked, R29 stated she fell, and then went on to say that she did not ask for help and that nobody had

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assisted her, and it was hard to get herself back up. An x-ray completed at 7:59 p.m. revealed a fracture of the distal right clavicle. The care plan at the time of incident was followed.

Review of R29's Incident Details/Fall Scene Investigation Report 8/20/17, revealed the following:

-8/20/17, at 12:45 a.m. staff heard a noise and found R29 on the floor outside her room, with her walker in her room. R29 was disorientated and indicated she was going to close the door and "buff the floor." The report identified R29 had been observed earlier in the shift taking alarms off herself. R29 denied discomfort at that time. The report indicated staff were to place bed alarm out of resident sight and reach, so she would not take off the alarm or turn the alarm off. On 8/21/17, R29 indicated she had discomfort in her left leg and hip area, guarding of the area and was unwilling to transfer. A x-ray completed at that time, identified an acute intertrochanteric fracture of the left femur associated with 90 degrees varus angulation of the femoral shaft fragment. An IDT meeting note dated 8/22/17, identified staff noted that R28 had removed her TABS alarm earlier in the shift and was talking delusional and was unsettled earlier in the shift. The note indicated the immediate intervention was to reapply the TABS alarm and place where she could not remove it herself. The note indicated on 8/21/17, R29 had complained of left leg and hip pain, guarded leg and was unwilling to transfer. Further, the note indicated R29 had been transferred to the hospital for evaluation of a left hip fracture. The note indicated R29's care plan had been followed. No further analysis of R29's fall was documented. However, despite

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R29's repeated removal/unhook of alarms, no other interventions had been implemented prior to R29's fall on 8/20/17.

Review of R29's progress notes revealed the following:

-8/20/17, at 12:45 a.m. staff heard a noise coming from R29's room. She was on the floor outside of her room and her walker was inside her room. R29 stated she was going to shut the door and buff the floor. R29 sustained a 2 centimeter bump on her head and denied discomfort. Ice was applied. R29 was assisted back to bed with assistance of 2 staff and gait belt. R29 was observed to unhook alarm at this time. Informed she needed to keep the alarm on and R29 continued to play with alarm buttons. Alarm moved out of reach of R29.

-8/21/17, at 8:30 a.m. R29 complained of left hip pain when she was sitting in her wheelchair. R29 was guarding her left leg. R29's primary physician was notified, and orders for x-ray were received.

-8/21/17, at 10:00 p.m. x-ray results indicated fracture of left hip. R29's primary physician was notified. Orders for foley catheter, to keep resident on bed rest, NPO (no oral intake) after midnight and to transfer for surgery in the morning.

Review of submission to OHFC identified the report had been submitted on 8/22/17, at 8:55 a.m.

Review of R29's investigation summary of the 8/20/17, incident revealed on 8/20/17, at 12:45

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a.m. staff heard a noise coming from the proximity of R29's room. Staff observed her outside her room on the floor. R29 indicated to the staff she was going to close the door so that she could buff the floor. Was noted earlier in the shift to be restless and had some delusional behaviors. R29 denied pain at that time. The next day she complained of pain, and an x-ray was completed at 9:30 p.m. and revealed a left hip fracture. The care plan at the time of incident was followed.

During interview on 9/20/17, at 12:56 p.m. with the administrator and director of nursing (DON), the administrator confirmed the current facility policy and stated the facility had 24 hours to report to SA. She stated she was aware of the requirement for 2 hour reporting for serious injury and confirmed the facility's current policy reflected that time requirement. At 12:58 p.m. the DON stated the usual practice was to report immediately, no later than 24 hours to SA. She stated she was not aware of the requirement to report cases of serious injury within 2 hours of knowledge. She confirmed the findings for R29 from 8/20/17, was a serious injury, and it had not been reported within 2 hours of knowledge of the injury. At 1:45 p.m. the administrator stated she had reviewed R29's fall on 6/12/17, with the staff members involved, and the staff had felt because R29 could tell them she fell, the incident did not meet the requirements for unknown injury to be reported in 2 hours.

On 9/20/17, at 3:04 p.m. during interview with registered nurse (RN)-A and licensed practical nurse (LPN)-A , RN-A confirmed R29 had severe cognitive impairment, and history of hallucinations. She indicated she felt R29 was a

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F 225	Continued From page 9 reliable historian related to the incident when R29's clavicle fracture was found. RN-A indicated she felt R29 was right on and sometimes she was not and felt her cognitive status was intermittent. RN-A indicated she felt R29 could still communicate effectively. On 9/21/17, at 7:16 a.m. RN-A confirmed she had talked with R29 after she was noted to have bruises on her shoulder and indicated R29 had told her she "fell", and had not asked for help and no one assisted her and it was hard for her to get up. She indicated she felt the cause of the bruising on R29 was from the reported fall. The facility policy titled, St Francis Health Services of Morris Skilled Nursing Facility Maltreatment Reporting Guidelines, reviewed/amended 11/18/16, included each care center must report to the state agency (OHFC) any suspected maltreatment, which included injuries of unknown source immediately, but not later than 2 hours if result in serious bodily injury.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and	F 226		10/27/17

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F 226	Continued From page 10 (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the facility vulnerable adult reporting policy regarding immediate reporting, not later than 2 hours, to the State agency (SA) for 2 of 3 (R29) incidents reviewed for abuse/neglect/neglect of care. R29 sustained an injury of unknown source that was not reported within 24 hours, and then when staff became aware of a fracture failed to report within 2 hours. R29 also sustained a fractured hip following a fall where fall interventions were not in place, and the facility failed to report potential neglect of care within 2 hours when aware of the fracture. In addition, the facility failed to implement policy for completion of a thorough investigation for 1 of 1 resident (R29) reviewed with a injury of unknown origin with serious bodily	F 226	F226 Browns Valley Health Center will follow the facility□s Maltreatment Policy and Procedure on VA reporting. All residents have the potential to be impacted by a deficient practice in this area. The facility□s Maltreatment Policy reporting guidelines were reviewed and revised on 9/30/17. All Charge Nurse staff will be re-educated on the updated Maltreatment Policy reporting guidelines. State Agency reporters will be re-educated on the care center□s Malpractice Policy reporting guidelines during the monthly Nurse□s meeting on 10/25/17.	

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F 226	Continued From page 11 injury. Findings Include: The facility policy titled, St Francis Health Services of Morris Skilled Nursing Facility Maltreatment Reporting Guidelines, reviewed/amended 11/18/16, included each care center must report to the state agency (OHFC) any suspected maltreatment, which included injuries of unknown source immediately, but not later than 2 hours if result in serious bodily injury. Review of R29's signed Physician Order Sheet, signed 9/5/17, identified diagnoses which included dementia with behavioral disturbance, chronic obstructive pulmonary disease and recurrent major depression. R29's quarterly Minimum Data Set (MDS) dated 6/6/17, identified R29 had diagnoses which included dementia, osteoporosis and depression. The MDS listed R29 had severe cognitive impairment, and required extensive assistance with dressing, hygiene, toileting, transfers and locomotion. Further, the MDS identified R29 had a fall since the prior assessment. R29's significant change MDS dated 8/31/17, identified R29 had severe cognitive impairment, required extensive assistance with dressing, hygiene, eating and locomotion, total assistance with transfers, toileting and did not walk. R29's current care plan printed on 9/20/17, at 3:04 p.m. last updated 8/21/17, at 3:23 p.m. by registered nurse (RN)-A identified R29 had a potential for abuse. The care plan also indicated R29 was at risk for falls or injury related to	F 226	All incidents will be monitored by the Administrator to ensure timely reporting to the State Agency is done. Audits will be done 4x week for 2 weeks, then 2x week for 2 weeks, then weekly. Nursing progress notes will be monitored every day to ensure that the appropriate State Agency reporting staff been notified of any incidents to determine need for accurate and timely VA reporting. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Performance Review team on 10/19/17 and quarterly to the full QAPI team on 11/14/17. The QAPI team will make recommendations for ongoing monitoring. Completion date for F226 is Oct. 27th, 2017	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 12 cognitive deficits and required assistance with activities of daily living (ADL)s. The care plan further indicated R29 did not remember that she needed assistance with transfer or ambulation, and instructed staff to anticipate her needs. Review of R29's Incident Details/Fall Scene Investigation Report from 6/12/17, revealed the following: -6/12/17, at 8:00 a.m. during a.m. cares R29 was disorientated, and complained of discomfort in her right shoulder with movement. A bruise on the top of her right clavicle region was noted, with swelling around the site. A scrape below her right knee was also noted. R29 winced with discomfort with movement of the area. The report indicated R29 reported, "I fell" and denied any assistance after the fall. The report listed staff were to use 2 for all transfers with a gait belt until after the portable x-ray was completed. The report indicated a portable x-ray done identified a fracture of her distal right clavicle. The record included written statements from staff dated which noted R29 had been assisted to bed at approximately 6:30 p.m. on 6/11/17, and had no visible bruises and no complaints of pain at that time. The staff statement indicated 5:00 a.m. rounds had been completed on 6/12/17, and she was sleeping at that time and no complaints of pain. A staff written statement dated 6/13/17, indicated the staff member had assisted R29 with morning cares on 6/12/17. The statement indicated during cares, R29 had indicated her arm hurt and staff found bruises on her shoulder and front of her right leg. The record also included written statements from 6/13/17, which indicated R29's bed had been unable to be put in low position a week prior and maintenance	F 226		

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	245564	A. BUILDING _____ B. WING _____	09/22/2017

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personnel had been notified of the broken bed. Maintenance had determined new parts for the bed needed to be ordered, and adjusted the bed to the lowest position, and would remain in that position until the new part installed. The written statement from maintenance personnel dated 6/13/17, indicated he had set the bed in approximately 3 inches higher than the lowest position possible, ordered the needed parts for the bed and installed the parts on 6/13/17. An IDT meeting note dated 6/13/17, indicated R29 had been noted to have bruising and complaints of pain in her right shoulder during morning cares. The note indicated staff had asked R29 what happened and she had stated she fell and nobody had helped her get up. R29's care plan was revised to include 2 assist for transfers at that time. No documentation of further investigation of the cause of R29's injury was noted, no further analysis of the effectiveness/use or function of the safety devices in place had been completed.

Review of R29's progress notes revealed the following:

-6/12/17, at 8:15 a.m. R29 grabbed and squeezed right shoulder winced and complained of pain. R29 had a bruise on top of her right clavicle region, swelling was noted around the site. A scrape was noted also below R 29's right knee. R29 stated she fell when asked, and when asked if anyone helped her she shook her head no. R29's primary physician was notified and orders were received for a PPX (portable x-ray). Two staff assistance for R29 with all transfers and transfer belt until PPX completed.

-6/12/17, at 7:59 p.m. results of x-ray indicated

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fracture of distal right clavicle. R29's primary physician was notified.

Review of submission to Office of Health Facility Complaints (OHFC) identified the report had been submitted on 6/13/17, at 1:07 p.m.

Review of R29's investigation summary of the 6/12/17, incident revealed on 6/12/17, during a.m. cares NAR (nursing assistant registered) staff indicated R29 complained of pain in her right shoulder area and noted a bruise and swelling at the top of the right clavicle region. When asked, R29 stated she fell, and then went on to say that she did not ask for help and that nobody had assisted her, and it was hard to get herself back up. An x-ray completed at 7:59 p.m. revealed a fracture of the distal right clavicle. The care plan at the time of incident was followed.

Review of R29's Incident Details/Fall Scene Investigation Report 8/20/17, revealed the following:

-8/20/17, at 12:45 a.m. staff heard a noise and found R29 on the floor outside her room, with her walker in her room. R29 was disorientated and indicated she was going to close the door and "buff the floor." The report identified R29 had been observed earlier in the shift taking alarms off herself. R29 denied discomfort at that time. The report indicated staff were to place bed alarm out of resident sight and reach, so she would not take off the alarm or turn the alarm off. On 8/21/17, R29 indicated she had discomfort in her left leg and hip area, guarding of the area and was unwilling to transfer. A x-ray completed at that time, identified an acute intertrochanteric fracture of the left femur associated with 90

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degrees varus angulation of the femoral shaft fragment. An IDT meeting note dated 8/22/17, identified staff noted that R28 had removed her TABS alarm earlier in the shift and was talking delusional and was unsettled earlier in the shift. The note indicated the immediate intervention was to reapply the TABS alarm and place where she could not remove it herself. The note indicated on 8/21/17, R29 had complained of left leg and hip pain, guarded leg and was unwilling to transfer. Further, the note indicated R29 had been transferred to the hospital for evaluation of a left hip fracture. The note indicated R29's care plan had been followed. No further analysis of R29's fall was documented. However, despite R29's repeated removal/unhook of alarms, no other interventions had been implemented prior to R29's fall on 8/20/17.

Review of R29's progress notes revealed the following:

-8/20/17, at 12:45 a.m. staff heard a noise coming from R29's room. She was on the floor outside of her room and her walker was inside her room. R29 stated she was going to shut the door and buff the floor. R29 sustained a 2 centimeter bump on her head and denied discomfort. Ice was applied. R29 was assisted back to bed with assistance of 2 staff and gait belt. R29 was observed to unhook alarm at this time. Informed she needed to keep the alarm on and R29 continued to play with alarm buttons. Alarm moved out of reach of R29.

-8/21/17, at 8:30 a.m. R29 complained of left hip pain when she was sitting in her wheelchair. R29 was guarding her left leg. R29's primary physician was notified, and orders for x-ray were

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received.

-8/21/17, at 10:00 p.m. x-ray results indicated fracture of left hip. R29's primary physician was notified. Orders for foley catheter, to keep resident on bed rest, NPO (no oral intake) after midnight and to transfer for surgery in the morning.

Review of submission to OHFC identified the report had been submitted on 8/22/17, at 8:55 a.m.

Review of R29's investigation summary of the 8/20/17, incident revealed on 8/20/17, at 12:45 a.m. staff heard a noise coming from the proximity of R29's room. Staff observed her outside her room on the floor. R29 indicated to the staff she was going to close the door so that she could buff the floor. Was noted earlier in the shift to be restless and had some delusional behaviors. R29 denied pain at that time. The next day she complained of pain, and an x-ray was completed at 9:30 p.m. and revealed a left hip fracture. The care plan at the time of incident was followed.

During interview on 9/20/17, at 12:56 p.m. with the administrator and director of nursing (DON), the administrator confirmed the current facility policy and stated the facility had 24 hours to report to SA. She stated she was aware of the requirement for 2 hour reporting for serious injury and confirmed the facility's current policy reflected that time requirement. At 12:58 p.m. the DON stated the usual practice was to report immediately, no later than 24 hours to SA. She stated she was not aware of the requirement to report cases of serious injury within 2 hours of

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F 226	Continued From page 17 knowledge. She confirmed the findings for R29 from 8/20/17, was a serious injury, and it had not been reported within 2 hours of knowledge of the injury. At 1:45 p.m. the administrator stated she had reviewed R29's fall on 6/12/17, with the staff members involved, and the staff had felt because R29 could tell them she fell, the incident did not meet the requirements for unknown injury to be reported in 2 hours. On 9/20/17, at 3:04 p.m. during interview with registered nurse (RN)-A and licensed practical nurse (LPN)-A , RN-A confirmed R29 had severe cognitive impairment, and history of hallucinations. She indicated she felt R29 was a reliable historian related to the incident when R29's clavicle fracture was found. RN-A indicated she felt R29 was right on and sometimes she was not and felt her cognitive status was intermittent. RN-A indicated she felt R29 could still communicate effectively. On 9/21/17, at 7:16 a.m. RN-A confirmed she had talked with R29 after she was noted to have bruises on her shoulder and indicated R29 had told her she "fell", and had not asked for help and no one assisted her and it was hard for her to get up. She indicated she felt the cause of the bruising on R29 was from the reported fall.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 241		10/27/17

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F 241	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a dignified dining experience for 3 of 3 residents (R4, R5, R29) who required assistance with eating during the supper meal on 9/18/17 in the dining room. Findings include: On 9/18/17, at 5:04 p.m. R4 was seated in a black and purple tilt in space (adjustable reclining) wheelchair positioned at the table with her meal in front of her. R29 was to the left of R4, seated in her wheelchair at the table with her meal in front of her. To the left of R29 was an empty chair and then R5 was seated in a black tilt in space wheelchair, reclined at a 45 degree angle. R5 had her meal in front of her, but her eyes were closed and she was breathing through her mouth. Next to R5 was nursing assistant (NA)-I. NA-I was seated in a chair, leaning her elbow on the table as she fed R4 spoonfuls of food, not talking with any of the residents. At 5:11 p.m. NA-I remained seated at the table with R4, R29 and R5. NA-I was leaned over the table on her elbows, leaning to the right side, and offered spoonfuls of food to R4. She did not talk, or engage R4 in conversation while she assisted her to eat, and did not talk or engage R29 or R5 during the meal. At 5:19 p.m., R29 coughed, NA-I stood up and walked over to R29 and offered her a glass of water. NA-I sat back down next to R4, resumed offering bites of food to R4. NA-I did not talk to R4 and did not engage her in conversation.	F 241	F241 Dignity Resident R4, R5, R29 will receive dignified care and treatment with regard to a dignified dining experience. All residents have the potential to be treated in an undignified manner, esp. those residents with cognitive impairments. Nursing staff will be re-educated on resident dignity, according to the facility policy. Included in this education is mandatory in-servicing on “Feeding with Dignity”. Staff will be reminded to immediately report any potential concerns related to resident dignity to their supervisor or any other member of the care center management staff. Staff education to take place on 10/19/17 and 10/20/17. Random observational audits will be done on all residents during meal times by the DON/designee a minimum of 4x week for 2 weeks, then 2x week for 2 weeks, then monthly thereafter. Results of the monitoring will be reviewed during the monthly Performance Review meeting on 10/19/17 and quarterly during the QAPI meeting on 11/14/17. The QI team will make recommendations for ongoing monitoring. Completion date for F241 is Oct. 27th 2017	

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F 241	Continued From page 19 At 5:22 p.m. NA-B approached the dining room table and sat next to R5 and called her name once. R5 did not open her eyes or respond to NA-B rubbing the top of her right leg. R5's wheelchair remained tilted at a 45 degree angle, NA-B did not attempt to adjust R5's wheelchair to an upright position and no further attempts from NA-B to wake R5. NA-B then turned to R29 and offered a bite of food. At 5:33 p.m., NA-I remained seated, leaning on the table with her elbows, feeding bites of food to R4. R29 continued to independently take bites of food and R5 remained seated in tilt in space wheelchair at a 45 degree angle with eyes closed. NA-I and NA-B did not talk or engage R4, R5, R29 in conversation. NA-B left the table and NA-F sat down at the table between R29 and R5. At 5:39 p.m. R5 remained seated at a 45 degree angle in wheelchair with eyes closed and mouth open. NA-I placed a spoonful of eggs into R5's mouth without attempting to wake her or encourage her to eat. NA-I used spoon to push the eggs to the back of R5 mouth to get a swallow response. NA-I repeated pushing the eggs to the back of her mouth until R5 swallowed. NA-I did not talk to R5, and R5 did not open her eyes. NA-I and NA-F talked with eath other, and discussed their individual hours of work schedule. At 5:41 p.m. NA-I and NA-F continued to discuss their work schedules. NA-I discussed her sleep schedule at home with NA-F, and discussed child's issues at home with NA-F. No engagement with R4, R29 or R5 was observed. NA-I continued to assist R4 with bites of food while talking with NA-F.	F 241		

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F 241	Continued From page 20 At 5:52 p.m. R4, R29 and R5 remained seated at the table with NA-I and NA-F. NA-F and NA-I continue to carry on a personal conversation between themselves, no attempts to engage the residents in conversation were observed. At 6:02 p.m. R4 and R29 were assisted to leave the dining room. On 9/18/17, at 7:45 p.m. NA-F confirmed she had been seated next to R5 during the supper meal. NA-F stated she felt R4, R5 and R29 kept to themselves at meals and confirmed she and NA-I continued in personal conversation with each other throughout the supper meal. On 9/21/17, at 2:46 p.m. NA-I confirmed she had assisted R4, R29 and R5 with the supper meal on 9/18/17. She confirmed she had a personal conversation throughout the entire supper meal with NA-F and had not engaged the residents in conversation. She indicated she was aware this was not a dignified experience for R4, R5 or R29. NA-I confirmed, staff had received reminders in the past to limit personal conversations while assisting residents with their meals. On 9/21/2017, at 2:56 p.m. director of nursing (DON) confirmed staff not engaging with residents during meal times was not acceptable practice. She indicated facility staff had been educated on assisting with meals and dignity in the past. Review of the undated policy titled Browns Valley Health Center Dignity Policy ,indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.	F 241		

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F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure a clean and sanitary environment was maintained for 2 of 4 resident rooms observed to have overflowing garbage's. Findings Include: On 9/19/17, at 9:52 a.m. a shared bathroom for residents R10 and R42, was observed to have a garbage pail overflowing with soiled incontinent products. An odor of urine was also observed to linger in the bathroom. On 9/20/17, at 8:41 a.m. nursing assistant (NA)-E indicated the facility NA's were not responsible for removing the garbage's in resident rooms when they were full. NA-E stated the facility housekeeping staff was responsible for removing residents garbage's when full. On 9/21/17, at 12:53 p.m. housekeeping (H)-A indicated resident rooms were cleaned every day, which included removing garbage in the bathroom. H-A indicated housekeeping staff were present in the facility Monday through Friday and only during day time hours. H-A indicated when housekeeping were not present in the facility, NA's were responsible to collect soiled garbage and remove the garbage from resident rooms. H-A further indicated when she would arrive in the early morning hours, she would routinely find R10's and R42's shared bathroom garbage	F 253	F253 Browns Valley Health Center will maintain a clean and sanitary environment. All residents having shared bathrooms have the potential to be impacted by a deficient practice in this area. Facility Odor Elimination Policy was reviewed and revised to include a process for maintaining an odor free environment. Nursing and Housekeeping staff will be re-educated on the process of removing soiled garbage in independent resident room/bathrooms by 10/25/17. Charge Nurse to assign staff each shift to empty garbage in independent shared rooms/bathrooms in order to eliminate odor. Larger garbage can with a lid, scented bags, and an automatic air freshener to assist with odor control added to room 117/118 shared bathroom. Audit sheets will be placed in room 117/118 shared bathroom for staff and housekeeping to sign off when the garbage is removed in order to eliminate odor from the bathroom each shift daily. Random audits of the sheets will be completed by DON/Housekeeping staff 4x week for 2 weeks, then 2x week for 2 weeks, then monthly thereafter. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported to	10/27/17

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F 253	Continued From page 22 overflowing with soiled incontinent products. H-A indicated in the past R42 had reported to her that her shared bathroom garbage was routinely overflowing with soiled briefs. H-A further indicated she had encouraged R42 to not pick up the soiled products from the floor and to let facility staff know if the garbage required changing before or after housekeeping arrived. R42's quarterly Minimum Data Set, dated 9/16/17, identified R42 had intact cognition. On 9/21/17, at 1:25 p.m. R42 indicated her shared bathroom garbage with R10 was routinely overflowing with soiled incontinent products. R42 stated she used to pick up the soiled products up from the bathroom floor when they would fall off of the pile, however she had been told not to pick them up and was directed to notify nursing staff. R42 stated she had spoken with a nurse, nurses assistant and activities, as recently as a few weeks ago, about her concern with the overflowing garbage and nothing had changed. R42 stated often times the soiled incontinent products would carry a strong odor of urine, which she could smell in her room. R42 further stated the evening staff routinely would not remove the soiled incontinent products from her bathroom, and the garbage would stay until the following morning. On 9/21/17, at 1:31 p.m. environmental services director (ED) indicated to his understanding if there were soiled incontinent products in residents rooms, it was the facility NA's who were responsible to remove the soiled garbage's when housekeeping staff were not in the facility. ED stated this would need to be on the evening and night shifts. ED further stated housekeeping	F 253	the monthly Performance Review team on 10/19/17 and quarterly QAPI meeting on 11/14/17. The QAPI team will make recommendations for ongoing monitoring. Completion date for F253 is Oct. 27th, 2017	

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would empty resident garbage's once a day and only more if requested by staff or residents.

On 9/21/17, NA-K stated her usual shift to work was the evening shift and her usual process would be to check residents garbage's at the end of the shift, prior to residents going to bed. NA-K further indicated she would often not check R10 and R42's shared bathrooms, as both residents were independent with activities of daily living.

On 9/21/47, at 3:51 p.m. NA-C indicated he worked all shifts and he would not routinely check garbage's on the south end of the building, which included R10 and R42's rooms and bathroom. NA-C indicated he would remove any soiled garbage's after he assisted residents with cares, however; residents who were independent with cares would not have their garbage's checked and changed at the end of the shift.

On 9/22/17, at 1:40 p.m. the director of nursing (DON) stated she would expect staff to clean up all residents rooms at the end of the shift to ensure the removal of soiled incontinent products, this would include R10 and R42's shared bathroom.

On 9/22/17, at 1:41 p.m. the social service designee/activity director indicated she was unaware R42 had concerns with her bathroom garbage.

On 9/22/17, at 2:30 p.m. the admissions coordinator indicated facility nursing staff had been told not to enter residents rooms to remove garbage's if the residents were sleeping. She further indicated there was not a current process in place to remove soiled incontinent products

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNS VALLEY HEALTH CENTER	114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 24 from resident rooms which were independent in cares, that included R10 and R42. An undated facility policy titled, Odor Elimination Policy, revealed it was the policy of the facility upon receiving a complaint regarding orders, steps would be taken to eliminate the odors. The policy did not address maintaining an odor free resident environment.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 1 resident (R13) reviewed for activities of daily living. Findings include: R13's quarterly MDS dated 6/15/17, indicated R13 had intact cognition and required extensive	F 274	F274 Resident R13 received a comprehensive sig. change assessment due to changes in cognition and ADL assistance with ARD of 10/13/17. Appropriate individualized interventions were developed based on the results of the comprehensive significant change assessment. IDT first decision to not do a sig. change was based on R13 ADL status as it did not change. R13 cognitive status has not	10/27/17

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F 274	Continued From page 25 assistance from two staff for transfers, dressing and toileting. R13 had no limitation in range of motion, did not require oxygen and was occasionally incontinent of bowel. R13 also had occasional pain that she was unable to rate and no falls since the prior assessment. R13's 5-day Prospective Payment System (PPS) MDS dated 8/28/17, indicated R13 had moderate cognitive impairment and required total assistance from two staff for bed mobility, transfers, dressing and toileting. R13 had a functional limitation in range of motion that interfered with daily functions to a lower extremity. R13 was frequently incontinent of bowel, required oxygen and had a surgical wound that required surgical wound care. R13 indicated she was frequently having moderate pain. R13 also had one fall with a major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma) with a diagnosis of a fracture other than a hip fracture. R13's quarterly MDS dated 9/3/17, indicated R13 had moderate cognitive impairment and required total assistance from two staff for transfers, dressing, and toileting. R13 had a functional limitation in range of motion that interfered with daily functions to a lower extremity. R13 was frequently incontinent of bowel, required oxygen and had a surgical wound that required surgical wound care. R13 indicated she was frequently having moderate pain and had a diagnosis of a fracture other than a hip fracture. Review of the above assessments indicated a decline in cognition from intact to moderately impaired, increase in need for assistance with activities of daily living (ADL) for transfers,	F 274	returned to normal since last assessment therefore the IDT decided to do a sig. change with an ARD of 10/13/17. All residents with a change of status will be reviewed to identify a need for comprehensive significant change assessments. Timely, accurate, comprehensive significant change assessments will be completed on residents identified with a significant change in condition. Staff involved with comprehensive significant change assessments will be re-educated on the process of identifying and completing a comprehensive significant change assessment on 10/20/17. Random audits of will be completed by the DON/designee of residents that have had a change of status to ensure significant changes are appropriately identified and completed accurately and timely. A min of 3 records will be reviewed weekly to ensure compliance. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Performance Review team on 10/19/17 and quarterly to the QAPI committee on 11/14/17. The QAPI committee will make recommendations for ongoing monitoring. Completion date for F274 is Oct. 27th, 2017	

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F 274	Continued From page 26	F 274		

dressing and toileting, new functional limitation in range of motion that interfered with daily functions to a lower extremity, a decline in bowel continence, increase in frequency of pain, increase in falls, new onset of a fracture, initiation of surgical wound care and oxygen use.

On 9/21/17, at 1:58 p.m. MDS coordinator stated she had completed R13's 5-day PPS assessment dated 8/28/17, as well as R13's quarterly MDS dated 9/3/17. MDS coordinator confirmed a discharge return anticipated (DCRA) MDS dated 8/17/17 was completed for R13. She confirmed the Resident Assessment Instrument (RAI) manual directed when a resident returned to the nursing home after a DCRA MDS, the IDT must determine if criteria are met for a SCSA MDS and if the criteria are met, a SCSA MDS must be completed. She also agreed the RAI manual indicated the need for a significant change assessment when two or more areas of change were noted and not expected to be self-limiting to 14 days. MDS coordinator stated after the hospitalization staff met to discuss R13 at the Monday morning therapy meeting and felt R13 did not require a SCSA MDS. MDS coordinator stated there was a progress note stating the decision in R13's medical record.

Review of progress note dated 8/21/17 indicated a late entry for 8/21/17 was made on 9/18/17 by director of nursing(who was identified by the facility as the previous MDS coordinator) stated: "Reviewed on return from hospital that resident ADL had not changed and pain is expected to decrease as Fx [fracture] heals. Determined not to do a Significant change in status assessment at this time".

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F 274	Continued From page 27 Facility provided policy titled, St. Francis Health Services of Morris MDS 3.0 Assessment, with a reviewed date of 4/6/15, indicated "Policy: To conduct a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI manual and regulations, Rules and Status [sic] specified by the Centers for Medicare and Medicaid and the State of Minnesota." The Resident Assessment Instrument manual dated 10/16, included the definition of a significant change as a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary (IDT) review and/or revision of the care plan. The manual further directed when the IDT determined that a significant change occurred, the nursing home should document the initial identification of the significant change in the clinical record. The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. The manual clarified that MDS assessments are not required for minor or temporary variations in resident status.	F 274		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		10/27/17

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F 278	Continued From page 28 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code falls according to the resident status for the Minimum Data Set (MDS) for 2 of 2 residents (R13, R29) reviewed for accuracy of the MDS.	F 278	F278 Resident R13, R29 has had modifications made to accurately code falls on (R29) DCRA MDS dated 8/22/17 and SCSA MDS dated 8/31/17. (R13) DCRA MDS	

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F 278	Continued From page 29 Findings include: R29's discharge return anticipated (DCRA) MDS dated 8/22/17, indicated R29 had one fall without injury since the last assessment period dated 6/6/17. R29's significant change in status (SCSA) MDS dated 8/31/17, indicated the facility was unable to determine if R29 had a fall one month prior to her reentry to the facility date of 8/25/17. The SCSA MDS dated 8/31/17, also indicated the facility was unable to determine if R29 had a fall in the past 2-6 months from R29's reentry date of 8/25/17, or if R29 had a fracture related to a fall in the last six months since reentry on 8/25/17. SCSA MDS dated 8/31/17 indicated R29 had been receiving care in the facility since 9/28/15. Review of R29's progress notes from MDS assessment date 6/6/17, through 8/25/17, indicated the following: - 6/12/17, at 8:15 a.m. R29 observed with a bruise to right clavicle area and stated, "I fell." R29's x-ray results showed a fracture of distal right clavicle. - 7/8/17, at 5:53 p.m. R29 had a fall in room 171's bathroom doorway. R29 did not have any injury from the fall. - 8/20/17, at 12:45 a.m. R29 had a fall outside of her room. R29's x-ray was positive for fracture of left hip. R13's DCRA MDS dated 8/17/17, indicated R13 had no falls since prior assessment dated	F 278	dated 8/17/17. For Resident R13 on 08/17/17 a discharge MDS attestation was completed on 09/28/17 and re-submitted to the state agency. For Resident R29 on 08/22/17 a discharge MDS attestation was completed on 09/28/17 and re-submitted to the state agency. For Resident R29 on 08/31/17 a sig. change MDS attestation was completed on 09/28/17 and re-submitted to the state agency. All residents require that MDS assessments must accurately reflect the resident's status. MDS's for all residents with falls in the last quarter will be reviewed for accuracy and will be modified as needed. Staff involved with MDS will be re-educated on the process of accurately coding the MDS for falls by 10/20/17. Random audits on an ongoing basis of MDS for residents with falls will be conducted by DON/designee to ensure accurate coding of falls, 2 X week X 2, then weekly thereafter. Audit results will be reported monthly to the Performance Review team on 10/19/17 and quarterly to the full QAPI committee on 11/14/17. The QAPI committee will make recommendations for ongoing monitoring. Completion date for F278 is Oct. 27th, 2017	

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F 278	Continued From page 30 6/15/17. Review of R13's progress notes from MDS assessment date 6/15/17, through 8/17/17, indicated the following: -8/17/17, R13 had a fall from bed with a fracture of left femur. On 9/21/17, at 1:58 p.m. interview with MDS coordinator (MDS)-C confirmed she had completed R29's discharge return anticipated MDS dated 8/22/17 and SCSA MDS dated 8/31/17, as well as R13's DCRA MDS dated 8/17/17. After reviewing R29's progress notes, MDS-C confirmed R29 did have a fall with major injury on 6/12/17, a fall without injury on 7/8/17, and a fall with major injury on 8/20/17. MDS-C confirmed R29's DCRA MDS dated 8/22/17, section J1900 C should have been coded 2 (for two falls with major injury) since the prior assessment on 6/6/17. After review of R13's progress notes, MDS-C confirmed R13 did have a fall with major injury on 8/17/17. MDS-C confirmed the DCRA MDS dated 8/17/17, section J 1800 should have been coded 1, indicating a fall since prior assessment, as well as section J1900 C should have been coded 1 (for one fall with major injury) since the prior assessment on 6/15/17. Facility provided policy titled, St. Francis Health Services of Morris MDS 3.0 Assessment, with a reviewed date of 4/6/15, indicated: "Policy: To conduct a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI manual and regulations, Rules and Status [sic] specified by the Centers for Medicare and Medicaid and the	F 278		

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F 278	Continued From page 31 State of Minnesota."	F 278		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to conduct a comprehensive falls assessment to determine effective interventions for 1 of 1 resident (R29) who had a history of multiple falls and sustained fractures. This deficient practice resulted in immediate jeopardy for R29.	F 323	F323 Browns Valley Health Center will conduct Comprehensive Fall Assessments to determine effective interventions for residents with falls. R29 had a Comprehensive Fall Assessment to determine effective	10/27/17

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F 323	Continued From page 32 The immediate jeopardy began on 6/12/17, when R29 had not been comprehensively assessed for the root cause of repeated attempts of self transfer and appropriate interventions implemented and was identified on 9/21/17. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 11:09 a.m. on 9/21/17. The immediate jeopardy was removed at 3:39 p.m. on 9/22/17, but noncompliance remained at the lower G scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include; Review of R29's signed Physician Order Sheet, signed 9/5/17, identified diagnoses which included dementia with behavioral disturbance, chronic obstructive pulmonary disease and recurrent major depression. R29's quarterly Minimum Data Set (MDS) dated 6/6/17, identified R29 had diagnoses which included dementia, osteoporosis and depression. The MDS listed R29 had severe cognitive impairment, and required extensive assistance with dressing, hygiene, toileting, transfers and locomotion. Further, the MDS identified R29 had a fall since the prior assessment. R29's significant change MDS dated 8/31/17, identified R29 had severe cognitive impairment, required extensive assistance with dressing, hygiene, eating and locomotion, total assistance with transfers, toileting and did not walk. The MDS identified they were unable to determine if R29 had a fall or fracture since the prior assessment. The MDS also identified R29 had no	F 323	interventions to prevent falls on 9/21/17. As a result of the assessment, the following interventions were added to the resident's care plan: Celexa was put on hold, additional Vitamin D, Hipsters applied, Toileting plan was revised, Hourly checks between 8p and 8a, and monitoring of attempts to self-transfer. All residents require adequate supervision and assistive devices to prevent accidents/injuries. Facility Fall Policy was reviewed and revised to include a Fall Analysis will be completed on all residents with 2 or more falls per quarter, to determine trends and revise the care plan. All resident falls in the past 6 months have been reviewed to determine a need for a Comprehensive Fall Assessment. A Comprehensive Fall Assessments will be completed on all residents who have had 2 or more falls in the past 6 months. And for all residents going forward with 2 or more falls per quarter a Fall Analysis will be competed. Charge nurse staff will be re-educated on accurate incident reports and fall scene investigation reports, the revised fall policy, and Comprehensive fall assessments at the monthly nurse's meeting on 10/25/17. Random audits of residents with 2 or more falls will be completed by DON/designee on a weekly basis to ensure there is a Fall Analysis to determine trends and effectiveness of interventions and that the care plan is updated. Audit results will be reported weekly to IDT team, monthly to Performance	

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F 323	Continued From page 33 falls since the prior assessment. However, R29 had sustained a fall with major injury noted on 6/12/17, a fall with no injury on 7/8/17 and a fall with major injury on 8/20/17. R29's Fall Risk Care Area Assessment (CAA) dated 9/7/17, indicated R29 was at risk for falls. The CAA indicated R29 had a history of falls last quarter and her most recent fall was 8/20/17. The CAA further indicated R29 had sustained a left hip fracture from the fall. The CAA indicated R29 had recent return from hospital, therapy department was working with R29 and safety precautions remained in place. Staff were alert to R29's risk factors for fall potential. R29's Fall Risk Assessment dated 9/7/17, identified R29 had a score of 24. The assessment indicated a resident whose score was over 9 was at risk for falls. No further Fall Risk Assessments were provided by facility. Review of R29's current care plan printed on 9/20/17, at 3:04 p.m., last updated 8/21/17, at 3:23 p.m., identified R29 had dementia, and was at risk for falls due to cognitive deficits. R29's care plan listed various interventions which included: use of a low bed, perimeter mattress, resident did not remember that she needed assistance with transfer or ambulate and directed to anticipate needs, inspect shoes/footwear for proper fit, reduced slip shoes, keep call light in easy reach, no skid strips in front of toilet, alarm on bathroom door to alert entering, gripper socks in bed, and safety bed/chair alarms and floor mat alarms for resident at all times. Review of the facility form titled NAR (nursing assistant registered) Care Sheet, dated 9/20/17,	F 323	Review team on 10/19/17, and quarterly to the QAPI team on 11/14/17. The QAPI team will make recommendations for ongoing monitoring. Completion date for F323 in Oct. 27th, 2017	

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directed staff to use 2 staff for transfers, and safety devices included alarm BR (bathroom) door TABS and wanderguard. No further fall interventions were listed on the care sheet.

On 9/19/17, at 11: 33 a.m. R29 was observed lying in her bed on her right side. Her bed was in a low position, and observed to have bilateral grab bars in place and a concave mattress. She had a colored mat located on the floor on the right side of her bed and a black pressure floor mat was present on the left side of her bed. She had a white rectangular box (TABS alarm unit) attached to the left grab bar on her bed, with a string running from the box to her shirt on her mid upper back.

On 9/20/17, at 2:17 p.m. R29 was observed lying in bed with the head of bed slightly elevated. The bed was in low position. Grab bars were observed in place and a concave mattress was on the bed. She had a TABS alarm unit attached to the left grab bar. The string from the unit was attached to her shirt with a metal clip on the front of her left shoulder. A black pressure floor mat alarm was in place on the left side of her bed, and a colored padded mat was on the floor on the right side of her bed.

On 9/21/17, at 5:28 a.m. R29 was observed lying on her back with eyes closed in her bed. The bed was in low position and had a concave mattress. There was a black pressure floor alarm on the floor near the left side of her bed and a colored padded mat on the floor on the right side of her bed. The TABS alarm unit was attached to the left grab bar with a red cord leading from the tab unit to under her back.

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Review of R29's Incident Details/Fall Scene Investigation Reports from 11/29/16 to 9/18/17, revealed the following:

-11/29/16, at 1:20 a.m. found on floor next to her bed, alert. The wheelchair was in front of her, brakes not on, and stockings were on her feet. The report identified R29 had socks on feet and slipped while attempting self transfer. The report indicated gripper socks were to be applied at bedtime, no alarms were utilized at the time of the fall, and no injury noted. An IDT (interdisciplinary team) meeting note dated 12/5/16, identified the root cause of fall was R29 self transferring and improper footwear. Gripper socks were applied to feet and maintenance was notified to place gripper strips next to the bed.

-11/29/16, at 10:20 p.m. found on the floor next to her bed. R29 was disorientated, incontinent of loose stool, stated she had been reaching for a stool, although she pointed to her nightstand. The report listed R29 had gripper socks on, and wore shoes on her feet. Staff were unaware when R29 had last toileted. An IDT meeting note dated 12/5/16, identified the root cause of fall was R29 self transferring and loose stools. Nurse to monitor BM pattern, move night stand closer to bed so resident able to reach from bed, TABS alarms applied.

-12/4/16, at 2:07 p.m. staff heard a loud sound and found sitting on the floor in front of her nightstand. R29 was disorientated, stated "my wrist" and rubbed her wrist, no injury noted. Staff looked under her bed and retrieved a bracelet on the floor under the bed. The bracelet was placed on R29's wrist. An IDT meeting note dated 12/5/16, identified the root cause of the fall was

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F 323	Continued From page 36 R29 resident appeared to attempt to get bracelet that fell under her bed when lost balance and fell off of bed. Evaluation sent to therapy in regards to number of falls. -1/24/17, at 6:50 p.m. staff had been assisting roommate and noticed R29 on the floor in her room outside her bathroom. R29 was disorientated, appeared to attempt self transfer, wheelchair alarm had been unhooked from resident and not sounding. No injuries were noted and a pad alarm placed in her wheelchair. An IDT meeting note dated 1/30/17, identified the root cause of fall was R29 slipped out of wheelchair while attempting self transfer. R29 had removed TABS alarm from self. Pad alarm was placed in chair as R29 disabled the TABS alarm. - 2/6/17, at 6:30 p.m. found sitting on the floor near the conference room, with her back leaning against a geri-chair. R29 was disorientated, wheelchair next to her, with brakes on. TABS alarm had been attached to resident, resident removed clip, alarm not sounding. No injury noted. The report identified R29 had self transferred to a geri-chair which was stored in front of the conference room. The geri-chair was removed from the common area and properly stored in the conference room with doors shut. No IDT meeting notes were found. -2/12/17, at 7:20 p.m. found on floor with her back against the wall, in her bathroom. R29's mental status was normal for her, and had fall while self transferring. She had removed the wheelchair alarm, which had been hooked on the back of her shirt. The report listed a secondary alarm on the bathroom floor, had not been	F 323		

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activated by staff. R29 expressed some discomfort across her upper torso and chest area, and a chest x-ray completed on 2/13/17, revealed no acute findings. Staff educated on the use of the secondary alarm, toileting plan. An IDT meeting note dated 2/13/17, identified R29 had taken self to toilet and fell. TABS alarm was placed on bathroom door to alert staff of taking self to toilet. An addendum dated 9/20/17, (during survey) identified the care plan was not followed as bathroom door alarm had already been in place. The notes did not address how to deal with R29 removing alarms.

-3/28/17, at 7:45 p.m. found on the floor in her room near her bed. R29 was disorientated, and indicated she was going to bed. No injury noted. No alarm was observed on her wheelchair at that time. Wheelchair alarm applied at that time. An IDT meeting note dated 4/3/17, identified R29 had been attempting to transfer self into bed and fell. The note indicated R29's care plan had been followed, the immediate intervention put in place was the use of a TABS alarm on the wheelchair to alert staff of any self transfer. However, R29's clinical record indicated the alarm on her wheelchair had been in place during R29's 1/24/17, 2/6/17, and 2/12/17 falls and a pad alarm had been placed on R29's wheelchair after R29's 1/24/17 fall. The note lacked any further documentation of analysis of R29's fall.

-6/12/17, at 8:00 a.m. during a.m. cares R29 was disorientated, and complained of discomfort in her right shoulder with movement. A bruise on the top of her right clavicle region was noted, with swelling around the site. A scrape below her right knee was also noted. R29 winced with discomfort with movement of the area. The report indicated

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F 323	Continued From page 38 R29 reported, "I fell" and denied any assistance after the fall. The report listed staff were to use 2 for all transfers with a gait belt until after the portable x-ray was completed. The report indicated a portable x-ray done identified a fracture of her distal right clavicle. The record included written statements from staff dated which noted R29 had been assisted to bed at approximately 6:30 p.m. on 6/11/17 and had no visible bruises and no complaints of pain at that time. The staff statement indicated 5:00 a.m. rounds had been completed on 6/12/17 and she was sleeping at that time and no complaints of pain. A staff written statement, dated 6/13/17 indicated the staff member had assisted R29 with morning cares on 6/12/17. The statement indicated during cares, R29 had indicated her arm hurt and staff found bruises on her shoulder and front of her right leg. The record also included written statements from 6/13/17, which indicated R29's bed had been unable to be put in low position a week prior and maintenance personnel had been notified of the broken bed. Maintenance had determined new parts for the bed needed to be ordered, and adjusted the bed to the lowest position, and would remain in that position until the new part installed. The written statement from maintenance personnel dated 6/13/17 indicated he had set the bed in approximately 3 inches higher than the lowest position possible, ordered the needed parts for the bed and installed the parts on 6/13/17. An IDT meeting note dated 6/13/17, indicated R29 had been noted to have bruising and complaints of pain in her right shoulder during morning cares. The note indicated staff had asked R29 what happened and she had stated she fell and nobody had helped her get up. R29's care plan was revised to include 2 assist for transfers at	F 323		

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that time. No documentation of further investigation of the cause of R29's injury was noted, no further analysis of the effectiveness/use or function of the safety devices in place had been completed.

- 7/8/17, at 8:55 a.m. R29 was found lying on her side on the floor, in the doorway of another resident's bathroom. The report listed R29 had unhooked her alarm, gotten up without assistance, removed her shoes and TABS alarm and was in stocking feet. No injuries noted. A TABS alarm pressure pad was placed in her wheelchair to alert staff to her needs. An IDT meeting note dated 7/10/17, indicated R29 was found crawling on the floor outside of another resident's bathroom. The note indicated R29 had no injury, and care plan had been followed. The immediate intervention was for implementation of a pressure pad in her wheelchair to alert staff to self transfers. No further analysis of the fall was documented. However, R29's clinical record indicated a pad alarm had been placed on R29's wheelchair after the 1/24/17 fall. Despite the facility having knowledge R29 repeatedly removed/unhooked alarms previously, analysis of R29's fall interventions and use of alarms had not been completed.

-8/20/17, at 12:45 a.m. staff heard a noise and found R29 on the floor outside her room, with her walker in her room. R29 was disorientated and indicated she was going to close the door and "buff the floor." The report identified R29 had been observed earlier in the shift taking alarms off herself. R29 denied discomfort at that time. The report indicated staff were to place bed alarm out of resident sight and reach, so she would not take off the alarm or turn the alarm off. On

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8/21/17, R29 indicated she had discomfort in her left leg and hip area, guarding of the area and was unwilling to transfer. A x-ray completed at that time, identified an acute intertrochanteric fracture of the left femur associated with 90 degrees varus angulation of the femoral shaft fragment. An IDT meeting note dated 8/22/17, identified staff noted that R29 had removed her TABS alarm earlier in the shift and was talking delusional and was unsettled earlier in the shift. The note indicated the immediate intervention was to reapply the TABS alarm and place where she could not remove it herself. The note indicated on 8/21/17, R29 had complained of left leg and hip pain, guarded leg and was unwilling to transfer. Further, the note indicated R29 had been transferred to the hospital for evaluation of a left hip fracture. The note indicated R29's care plan had been followed. No further analysis of R29's fall was documented. However, despite R29's repeated removal/unhook of alarms, no other interventions had been implemented prior to R29's fall on 8/20/17.

Review of R29's progress notes from 11/29/16 to 9/20/17, revealed the following:

-11/29/16, at 1:30 a.m. R29 was found on floor, sitting next to bed, wheelchair in front of her, brakes not locked. Denied pain. Was in stocking feet, gripper socks applied. Maintenance notified to put down grippy strips next to her bed. Hourly checks tonight for safety.

-11/29/16, at 10:29 p.m. R29 was found sitting on floor next to her bed. Was wearing gripper socks and shoes. Her wheelchair was behind her. Denied pain. R29 indicated she was reaching for stool, but pointed towards nightstand. Put back

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F 323	Continued From page 41 into bed, TABS alarm in place. -12/4/16, at 2:25 p.m. staff heard loud sound, found R29 on the floor in front of her nightstand. R29 indicated her wrist and rubbed it. Looked under bed and found bracelet, retrieved and placed bracelet on R29's wrist. No injury noted. -12/6/16, at 7:39 a.m. R29 identified as fall risk with safety interventions in place. Has had falls this quarter. Last fall 12/4/16. Grab bars and perimeter mattress used. -12/12/16, at 1:30 p.m. Therapy evaluation completed. R29 was appropriate for activity therapy services. Review of R29 identified she had multiple falls and review of safety interventions in place completed. -1/16/17, Discontinued from active therapy. Restorative AROM(active range of motion)/Toileting program to continue. -1/24/17, at 11: 58 p.m. R29 was found on the floor outside the bathroom at 6:50 p.m. No injury noted. Placed a pad alarm on chair. Cause of fall identified alarm was on chair and unhooked. -2/6/17, at 7:23 p.m. R29 was found at 6:30 p.m. sitting on floor with back leaning against Geri-chair with wheelchair next to resident with brakes on. R29 had removed the clip from the alarm and it was not sounding. No injury noted. Geri-chair removed from common area and properly stored in conference room with doors shut. -2/12/17, at 10:56 a.m. R29 was found sitting on floor of bathroom. R29 had self transferred. R29	F 323		

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complained of chest pain and mid area sharp. Message left for primary physician.

-3/13/17, at 1:35 p.m. R29 had falls in last quarter. Last fall was 2/12/17. Note indicated R29 had severe cognitive impairment with a BIMS score of 5. R29 has rolled out of bed in the last 3 months and a perimeter mattress is used. R29 has history of chest pain from previous fall. The follow up x-ray indicated no fracture.

-3/20/17, at 4:31 p.m. note indicated R29 recognized objects and people, but did not recognize place, time or situation

-5/21/17, at 1:49 p.m. note indicated a review of R29's safety devices was completed. Falls risk assessment indicated she was at risk for falls. Does wander in wheelchair. Is inconsistent in asking for help and does attempt independent transfer in and out of bed and chair. Currently using an alarm on bathroom door and alarms used in bed, wheelchair and lift chair. Toileting program remains in place. Will continue usage of alarms in plan of care.

-6/8/17, at 2:14 p.m. At risk for falls, R29 had had falls this quarter, last fall 3/28/17, and safety interventions in place. R29 has severe cognitive impairment and disorientated to time and place. Last noted fall from bed was 3/28/17, and R29 had a perimeter mattress in place. No changes to bowel and bladder assessment or interventions. No changes or updates to plan of care.

-6/12/17, at 8:15 a.m. R29 grabbed and squeezed right shoulder winced and complained of pain. R29 had a bruise on top of her right

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clavicle region, swelling was noted around the site. A scrape was noted also below R29's right knee. R29 stated she fell when asked, and when asked if anyone helped her she shook her head no. R29's primary physician was notified and orders were received for a PPX (portable x-ray). Two staff assistance for R29 with all transfers and transfer belt until PPX completed.

-6/12/17, at 7:59 p.m. results of x-ray indicated fracture of distal right clavicle. R29's primary physician was notified.

-6/13/17, at 5:29 p.m. R29 had increased difficulty with transfers since incident. R29's primary physician was called and new orders received for clavicle strap to use as needed for comfort and physical therapy may evaluate and treat to direct safe transfers.

-6/14/17, at 1:52 p.m. A care conference was held and 90 day assessments were completed. Assessment indicated falls, wanderguard, bed/chair/floor alarms, bed low, anti-roll backs. No further documentation related fall assessment documented.

-6/30/17, at 10:11 p.m. R29 was very anxious and attempting to get out the doors of the facility. Staff explained this was her home.

-7/5/17, at 2:27 a.m. R29 was up in her wheelchair from 12:10 a.m. to 2:00 a.m. R29 had wheeled herself to the north and south doors and both times the alarm went off.

-7/5/17, at 3:16 p.m. new order from primary physician to discontinue the clavicle strap, to do a follow up clavicle x-ray and for physical and

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occupational therapy to evaluate and treat for post clavicle fracture.

-7/8/17, at 5:53 p.m. R29 was in another resident's bathroom doorway lying on her right side. R29 had removed her shoes and removed her TABS alarm. No injury noted. A TABS pressure alarm was placed in her wheelchair seat. Further, the note included "Remember, alarms do not prevent falls, they just alert staff to resident whereabouts, so if not alarming, is not included as care plan not being followed, therefore is not reportable."

-7/12/17, at 11:55 a.m. R29 had declined in activity tolerance, strength, and transfers were more difficulty. R29 was unable to walk since recent fracture. Orders received for therapy to evaluate and treat.

-7/26/17, at 10;14 a.m. Chest of drawers was secured to wall. Care plan was followed.

-7/26/17, at 10:36 a.m. active therapy services discontinued and restorative program remained in place.

-8/16/17, at 5:38 a.m. R29 was in her wheelchair from 1:00 a.m. to 3:30 a.m. The note indicated R29 told the writer that the girl needs cough syrup, but she did not. R29 ambulated out to the lobby and watched TV for awhile.

-8/19/17, at 7:15 p.m. R29 was attempting to get outside and her wanderguard alarm was going off. One to one visit completed and resident toileted.

-8/20/17, at 12:00 a.m. R29 was setting off alarm

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on her bed. R29 was assisted to the bathroom then back to bed and alarms were activated.

-8/20/17, at 12:30 a.m. R29's bed alarm was ringing and R29 informed staff that she had woodticks. Staff checked R29 and found no woodticks. Bed alarm and floor mat were activated. Call light was within reach.

-8/20/17, at 12:45 a.m. staff heard a noise coming from R29's room. She was on the floor outside of her room and her walker was inside her room. R29 stated she was going to shut the door and buff the floor. R29 sustained a 2 centimeter bump on her head and denied discomfort. Ice was applied. R29 was assisted back to bed with assistance of 2 staff and gait belt. R29 was observed to unhook alarm at this time. Informed she needed to keep the alarm on and R29 continued to play with alarm buttons. Alarm moved out of reach of R29.

-8/20/17, at 4:37 a.m. R29's bed and floor pad were on and not within reach. Denied any discomfort.

-8/21/17, at 8:30 a.m. R29 complained of left hip pain when she was sitting in her wheelchair. R29 was guarding her left leg. R29's primary physician was notified, and orders for x-ray were received.

-8/21/17, at 1:00 p.m. R29 was repositioned every 2 hours and was rolled to support her left leg. Ice was applied for comfort. R29 showed signs of pain with repositioning and guarded her left leg and hip area.

-8/21/17, at 9:00 p.m. x-ray of pelvis and left hip.

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F 323	Continued From page 46 -8/21/17, at 10:00 p.m. x-ray results indicated fracture of left hip. R29's primary physician was notified. Orders for foley indwelling urinary catheter, to keep resident on bed rest, NPO (no oral intake) after midnight and to transfer for surgery in the morning. -8/25/17, at 4:15 p.m. R29 returned from hospital for left femur fracture and left hip fracture. New orders received, including PT (physical therapy) and OT (occupational therapy) to evaluate and treat. -8/26/17, at 6:11 a.m. R29 had left hip pinned on 8/23/17, PT evaluation 8/25/17. Hoyer lift for all transfers. -8/29/17, at 3:59 a.m. R29 exercised poor judgement and did not use call lights. Low bed, bed alarm, floor pad in place and activated. Call light was within reach. -8/30/17, at 9:00 a.m. care conference was completed and 90 day assessments were reviewed including R29's comprehensive report. Safety indicated falls, wanderguard, bed/chair/floor alarms,bed low, anti-rollbacks. No further documentation of a comprehensive assessment of R29's falls was documented. -9/1/17, at 3:30 p.m. R29 had severe cognitive impairment. R29's health status had changed with recent hip fracture and pinning. R29 had experienced lethargy and poor appetite. -9/5/17, at 11:41 a.m. review of progress notes. On 9/5/17, at 8:50 a.m. has had falls this quarter, last fall 8/20/17, fall risk noted, safety	F 323		

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interventions in place. Hoyer used for R29's transfers and she was unable to walk. R29 identified as at risk for falls. Staff noted fall risk potential as recent.

-9/6/17, at 1:35 p.m. care conference held and 90 day assessments reviewed including Resident Comprehensive Report. Fall, wanderguard, bed/chair/floor alarms, bed low, anti-rollbacks. No further documentation of R29's fall assessment was documented.

-9/8/17, at 3:15 p.m. PT evaluation completed and R29 appropriate for active therapy services.

-9/13/17, at 9:00 p.m. comment added by registered nurse (RN)-A 9/20/17, at 2:12 p.m. on 9/13/17 (during survey) a review of R29's safety devices was completed during weekly PPS-modifications made as directed.

-9/19/17, at 4:04 a.m. R29 was restless and trying to climb out of bed. R29 was assisted up to the wheelchair with extensive assistance of 2 staff. R29 refused to go to the bathroom at that time. Acetaminophen 325 mg X 2 tablets were given to the resident for right hip and leg pain. R29 was unable to rate pain, and her incision site was dry and intact. R29 was given pudding for a snack.

-9/20/17, at 4:36 p.m.(during survey) R29's safety devices currently in place were reviewed by IDT. Note indicated to continue to problem solve to meet her safety needs. Staff interview indicated R29 was not actively pulling at alarm strings/devices. R29's plan of care was modified to meet her needs. R29 was being seen by active therapy services. Screen was to be sent to

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	245564	A. BUILDING _____ B. WING _____	09/22/2017

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BROWNS VALLEY HEALTH CENTER	114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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therapy to review current safety device/interventions in place and aide with problem solving to meet R29's needs.

During interview on 9/20/17, at 1:39 p.m. NA-A indicated the last time she was aware R29 attempted to take the alarm off was several weeks ago, "maybe a month or two ago."

On 9/20/17, at 2:02 p.m. NA-D indicated staff utilized a TAB alarm in her bed and wheelchair for R29 and she also had an alarm on her bathroom door. She stated R29 did not use her call light. She indicated R29 was at risk of falls. She indicated R29 had removed her alarms in the past, but was not aware of her doing it lately.

On 9/20/17, at 2:19 p.m. NA-E indicated R29 utilized a TAB alarm connected to her bed or wheelchair which staff clipped to the back of her shirt. She indicated R29 had not tried to remove her alarm in awhile. She indicated the facility had added a pressure floor mat alarm after her fracture. R29 utilized a cushioned pad on the floor on the side near the window, but she had never seen her get out of bed on that side.

On 9/20/17, at 2:38 p.m. NA-C indicated staff watched R29 for falls. He indicated R29 utilized a TAB alarm and indicated he was aware R29 self transferred. He indicated R29 attempted to self transfer at least once a day, and the most recent time he was aware of R29's self transfer was the last evening at approximately 7:00 p.m., when he heard the floor alarm pad sound. NA-C indicated he did not feel R29 could remove the TAB alarm herself.

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F 323	Continued From page 49 On 9/20/17, at 2:49 p.m. during group interview with RN-A and licensed practical nurse (LPN)-A, RN-A indicated LPN-A completed fall assessments for the facility. RN-A indicated her last fall risk assessment had been completed on 9/7/17, and she scored 24, and a score of anything over 9 indicated the resident was at risk of falls. RN-A stated R29 had fallen in June and broke her clavicle and fractured her hip with her most recent fall. She indicated the facility had made many changes to R29's care plan because staff needed to provide much more assistance to R29. RN-A indicated the facility reviewed falls routinely in a weekly therapy meeting which she identified as a interdisciplinary meeting. At that time, interventions were reviewed and changes were made as needed. RN-A indicated the facility documented the meeting in a IDT note in each resident's chart. However, the fall scene investigation forms and IDT meetings failed to comprehensively assess R29's risk for falls to include but not limited to trends/patterns to falls, factors that may be causing the falls, and effectiveness of interventions. On 9/20/17, at 3:04 p.m. LPN-A indicated after R29's clavicle fracture the facility had increased staff to 2 assist with ADLs (activities of daily living) and the floor pressure alarm had been added after her hip fracture. RN-A confirmed R29 had severe cognitive impairment, history of hallucinations and indicated she felt R29 was a reliable historian related to the incident when R29's clavicle fracture was found. RN-A indicated she felt R29 was right on and sometimes she was not and felt her cognitive status was intermittent. RN-A indicated she felt R29 could still	F 323		

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communicate effectively. LPN-A indicated she was aware R29 had a history of removing her alarm and continued to remove her alarms. RN-A indicated she felt R29 would not be candidate for 1 hour checks, and she had no consistency with toileting patterns in the past. RN-A stated staff were in R29's room a lot, because of her roommates condition, but the facility had never put in a formal program for R29 safety checks.

On 9/20/17, at 4:16 p.m. director of nursing (DON) confirmed R29's current care plan and indicated her care plan should of been updated to include applying the TABS alarm in a place where she could not remove it when this was discussed on 8/22/17. The DON confirmed it also should have been updated on the NAR care sheet. During review of R29's electronic health record with surveyor, the DON stated there were inconsistencies with the computer data related to the placement of the clip for the alarms and was unable to explain the inconsistencies. At 4:29 p.m. DON stated she had been made aware of revisions to the care plan made at that time, and felt that was the reason for the inconsistencies. She indicated she assumed the intervention related to placement of the clip for alarm was removed because it was no longer effective.

During follow up interview at 4:39 p.m. DON indicated licensed staff had talked with staff and found out R29 had no longer tried to remove her alarm, so she felt that intervention was no longer needed. She confirmed R29 was restless, but indicated she felt she had not tried to remove her alarm or self transfer. DON stated she was not aware of the self transfer attempt documented in R29's medical record on 9/19/17.

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F 323	Continued From page 51 On 9/21/17, at 5:31 a.m. RN-B stated R29 was sometimes restless at night and indicated R29 had slept very well at present. RN-B felt R29 had slept better last night because her roommate was out of the room during the night. RN-B indicated the roommate would make noise and wake up R29. RN-B indicated she had not witnessed R29 try to self transfer since her fractured hip, but she indicated she was aware other staff had reported R29 continued to attempt self transfers since her fractured hip. She indicated she had witnessed R29 attempt to self transfer approximately one week prior, when she assisted R29 to put her legs back into bed. She stated R29 had dementia and indicated R29 at times would understand what staff say to her and at other times not. RN-B indicated the last time she was aware R29 attempted self transfer was earlier that night when a nursing staff informed her of the self transfer. RN-B indicated R29 utilized a floor alarm, TABS alarm and she indicated the facility staff checked her frequently. RN-B stated the facility had implemented hourly checks last night and stated R29's floor alarm had been in place for a few months, but was unsure exactly how long it had been utilized. RN-B indicated she was aware R29 knew how to take her TABS alarm off and that she had shut off the pressure floor alarm. She indicated R29 took the TABS alarm off herself every other day or every third day. RN-B indicated R29 was confused at times, was difficult to know if she understood and indicated that was her normal state. On 9/21/17, at 5:54 a.m. trained medication aide (TMA)-A indicated R29 utilized a TABS alarm and indicated R29 always took it off. She indicated R29 had been able to remove the clip of the TABS alarm, from wherever it was placed.	F 323		

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TMA-A indicated R29 also had a pressure floor alarm and stated the alarms had been in place a long time, and the floor pressure alarm on the floor had been used for R29 6 months or more. TMA-A indicated she also had a door alarm on her bathroom to alert staff also. TMA-A indicated R29 had confusion and communicated in only a few words. TMA-A stated R29 sometimes tried to get up on her own, and she could get herself onto the edge of the bed.

On 9/21/17, at 5:46 a.m. NA-G indicated R29 was confused, utilized a floor pressure alarm, which had been in place prior to the fractured hip. She indicated she was not aware R29 had attempted self transfer since she had her hip fracture.

On 9/20/17, at 6:00 a.m. NA-H stated R29 was confused andhe was aware R29 had attempted self transfer the night before, when she had indicated she saw a girl running around and wanted to get up and find her. He stated he had been assisting R29's roommate when this occurred. NA-H stated the alarm had not sounded yet, but saw her attempting to get up and last night was the most recent self transfer attempt he was aware of.

On 9/21/17, 6:38 a.m. LPN-A indicated the usual facility practice when a resident fell was for the charge nurse to assess the resident for injury,and if injury was present she would address the injury. She then would look at the environment for determining cause for fall, the root cause and put immediate interventions in place. She indicated on Mondays the facility held therapy/IDT meetings and falls were reviewed at the meetings and documentation of the meetings were done. LPN-A confirmed she was responsible for

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completion of the fall assessments and LPN-A stated the facility completed comprehensive fall assessments for admissions, annually, hospital returns and change of conditions. She indicated she had assisted with the investigation of R29's incident on 6/12/17, which resulted in the clavicle fracture. She indicated another nurse had interviewed R29 and R29 was able to answer questions at that time. LPN-P indicated therapy was initiated, a clavicle brace was utilized and assistance of 2 staff for transfers were contained. She stated R29 had another fall on 7/8/17, and stated a pressure alarm was placed in R29's wheelchair at that time. LPN-A indicated R29 was confused at times and verified R29 was delusional earlier on the shift of 8/20/17. LPN-A indicated she thought the pressure floor alarm was initiated when R29 returned from the hospital. After review of R29's progress note dated 8/20/17, at 12:30 a.m. with surveyor, she confirmed the pressure floor alarm was in place prior to the fall on 8/20/17. .

On 9/21/17, at 7:01 a.m. NA-I indicated R29 was a little confused, and had a TABS alarm in place for as long as she worked at facility and thought the pressure floor mat had been implemented since she broke her hip. She confirmed the current NAR care sheet did not include use of the tabs alarm or specific directions on how to place the alarm. NA-I indicated she had not witnessed R29 self transfer since she broke her hip. She indicated prior to that, R29 would attempt self transfer at least once a day.

On 9/21/17, at 7:16 a.m. RN-A confirmed R29's printed NAR care sheet dated 9/20/17 and confirmed R29's current care plan, printed 9/20/17. She indicated she had made changes to

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both the previous evening. RN-A confirmed she had talked with R29 after she was noted to have bruises on her shoulder and indicated R29 had told her she "fell", and had not asked for help and no one assisted her and it was hard for her to get up. She indicated she felt the cause of the bruising on R29 was from the reported fall.

On 9/21/17, at 7:37 a.m. DON stated her usual practiced was to document minutes of the IDT meetings for specific residents in the incident report. She indicated she maintained a log of incidents reviewed at the meetings, on a form titled BVHC Therapy meeting and confirmed documentation of a review of R29 after the 6/12/17 fall had not been done and confirmed R29 had been reviewed in the meeting after her 7/8/17 and 8/20/17 falls. At 8:00 a.m. DON stated R29 unhooking her alarm, footwear, toileting status and medical status was found to be the cause of R29's 7/8/17 fall. She confirmed R29 was found on the floor on 8/20/17 after staff had noted earlier she was removing her alarms and was confused. DON indicated the immediate intervention implemented at that time was to attach the TABS alarm in a place she could not remove herself. She verified no further interventions were implemented at that time. The DON stated the usual facility practice was for the charge nurse to complete an incident report and staff involved were to complete witness statements of the incident. The DON was notified, determined if the incident was a reportable event.

On 9/21/17, at 8:05 a.m. the DON indicated the usual facility practice for falls was for LPN-A to complete the comprehensive fall assessments, and the MDS coordinator reviewed the assessments and completed the care plans. She

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indicated a charge nurse would complete the incident report, utilized the fall investigation form to gather information for the report and then the IDT would review the fall at the routine meetings. She indicated the IDT would review the information sooner if needed. DON confirmed R29's current care plan and NAR care sheets. She confirmed R29 had removed the alarms herself on 7/8/17 and 8/20/17.

On 9/21/17, at 1:54 p.m. RN-A confirmed the comprehensive fall assessment done with the significant change MDS CAA on 9/7/17. She indicated she had reviewed R29's comprehensive fall assessments with DON and was unable to provide any further comprehensive fall assessments completed for R29.

Review of primary physician's progress notes from 6/2/17 to 9/2/17 revealed the following:

-6/2/17, R29 not very talkative but she denied chest pain or stomach pain, no back pain, no trouble breathing.

-7/8/17, R29 had fallen today, but was not hurt. Her x-ray indicated nondisplaced fracture of the distal end of the clavicle and that is ok.

-8/2/17, R29 complaint was she was tired.

-9/2/17; R29 was back from having her hip pinned. Her review of systems really not reliable because she does not respond much, but apparently no problems.

Review of Prairie Lakes Healthcare System hospital discharge summary, history and physical from R29's hospital stay from 8/22/17, to 8/25/17

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F 323	Continued From page 56 revealed the following: -Prairie Lakes Healthcare System history and physical dated 8/22/17; indicated review of systems unobtainable due to the patient's dementia. Due to the patient's dementia, risks, benefits and alternatives were discussed but unsure if the patient is truly understanding anything at this stage. -Prairie Lakes Healthcare System discharge summary dated 8/25/17, She does have chronic dementia, so unfortunately is limited on what she will answer when we ask he questions. Review of the facility policy titled St. Francis Health Services of Morris Accident/Incident reviewed and amended on 4/16/15 identified guidelines and procedures that adequately identify, assess, treat and prevent accidents and incidents that put the resident at risk for injury. The policy directed the IDT team to determine the root cause(s) of the incident, the best approaches to prevent reoccurrence and identify trends and patterns. A fall risk assessment would be completed upon admission, hospital returns, significant change of condition, if falls are triggered, on a 90 day review, annual review and any time a restraint was applied. As soon as possible, within 48-72 hours the Interdisciplinary team would complete the care center accident/incident follow up form to further assess probable causes of the incident and make any further recommendations. Once the assessment and causes have been completed, the interventions that were implemented by the nursing and or interdisciplinary team will be evaluated for effectiveness, and any other new interventions will be implemented. If not follow up	F 323		

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F 323	Continued From page 57 was necessary, it can be documented on the follow up section on the form. If follow up was necessary this would be done by the IDT in approximately a week from the date the team assessment was completed. If follow up is required sooner than a week, this would be documented on the form as well. If the quality assurance team identifies significant causes or trends, measures will be taken to correct the identified areas. The immediate jeopardy that began on 6/12/17, was removed on 9/22/17, when the facility comprehensively assessed R29 for falls, implemented effective interventions and revised the facility fall policies to include a fall analysis to be completed after 2 or more falls to determine trends and revise the care plan as needed. Intervention changes made for R29 included: Celexa put on hold, vitamin D added, hipsters, hourly checks between 8 p.m. and 8 a.m. and a tracking log for alarm activations for R29. R29's toileting plan was also revised to include scheduled toileting during the night hours. The non compliance remained at the lower scope and severity of G, isolated, and actual harm had occurred to R29.	F 323		

Electronically delivered
October 4, 2017

Ms. Autumn Roark, Administrator
Browns Valley Health Center
114 Jefferson Street South
Browns Valley, MN 56219

Re: State Nursing Home Licensing Orders - Project Number S5564027

Dear Ms. Roark:

The above facility was surveyed on September 18, 2017 through September 22, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00668	A. BUILDING: _____ B. WING _____	09/22/2017

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 18, 19, 20, 21 & 22, 2017 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 1 resident (R13) reviewed for activities of daily living. Findings include: R13's quarterly MDS dated 6/15/17, indicated R13 had intact cognition and required extensive assistance from two staff for transfers, dressing and toileting. R13 had no limitation in range of motion, did not require oxygen and was occasionally incontinent of bowel. R13 also had occasional pain that she was unable to rate and no falls since the prior assessment. R13's 5-day Prospective Payment System (PPS) MDS dated 8/28/17, indicated R13 had moderate	2 545	Corrected	10/27/17

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2 545	Continued From page 3	2 545		

cognitive impairment and required total assistance from two staff for bed mobility, transfers, dressing and toileting. R13 had a functional limitation in range of motion that interfered with daily functions to a lower extremity. R13 was frequently incontinent of bowel, required oxygen and had a surgical wound that required surgical wound care. R13 indicated she was frequently having moderate pain. R13 also had one fall with a major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma) with a diagnosis of a fracture other than a hip fracture.

R13's quarterly MDS dated 9/3/17, indicated R13 had moderate cognitive impairment and required total assistance from two staff for transfers, dressing, and toileting. R13 had a functional limitation in range of motion that interfered with daily functions to a lower extremity. R13 was frequently incontinent of bowel, required oxygen and had a surgical wound that required surgical wound care. R13 indicated she was frequently having moderate pain and had a diagnosis of a fracture other than a hip fracture.

Review of the above assessments indicated a decline in cognition from intact to moderately impaired, increase in need for assistance with activities of daily living (ADL) for transfers, dressing and toileting, new functional limitation in range of motion that interfered with daily functions to a lower extremity, a decline in bowel continence, increase in frequency of pain, increase in falls, new onset of a fracture, initiation of surgical wound care and oxygen use.

On 9/21/17, at 1:58 p.m. MDS coordinator stated she had completed R13's 5-day PPS assessment dated 8/28/17, as well as R13's quarterly MDS

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2 545	Continued From page 4 dated 9/3/17. MDS coordinator confirmed a discharge return anticipated (DCRA) MDS dated 8/17/17 was completed for R13. She confirmed the Resident Assessment Instrument (RAI) manual directed when a resident returned to the nursing home after a DCRA MDS, the IDT must determine if criteria are met for a SCSA MDS and if the criteria are met, a SCSA MDS must be completed. She also agreed the RAI manual indicated the need for a significant change assessment when two or more areas of change were noted and not expected to be self-limiting to 14 days. MDS coordinator stated after the hospitalization staff met to discuss R13 at the Monday morning therapy meeting and felt R13 did not require a SCSA MDS. MDS coordinator stated there was a progress note stating the decision in R13's medical record. Review of progress note dated 8/21/17 indicated a late entry for 8/21/17 was made on 9/18/17 by director of nursing(who was identified by the facility as the previous MDS coordinator) stated: "Reviewed on return from hospital that resident ADL had not changed and pain is expected to decrease as Fx [fracture] heals. Determined not to do a Significant change in status assessment at this time". Facility provided policy titled, St. Francis Health Services of Morris MDS 3.0 Assessment, with a reviewed date of 4/6/15, indicated "Policy: To conduct a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI manual and regulations, Rules and Status [sic] specified by the Centers for Medicare and Medicaid and the State of Minnesota." The Resident Assessment Instrument manual	2 545		

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2 545	Continued From page 5 dated 10/16, included the definition of a significant change as a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary (IDT) review and/or revision of the care plan. The manual further directed when the IDT determined that a significant change occurred, the nursing home should document the initial identification of the significant change in the clinical record. The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. The manual clarified that MDS assessments are not required for minor or temporary variations in resident status. SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) could provide inservice training to nursing staff on the requirement of re-assessment after a resident has significant change in status. An audit could be developed to ensure the required minimum data set assessments are implemented accurately and timely. The results could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 545		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		10/27/17

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2 830	Continued From page 6 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to conduct a comprehensive falls assessment to determine effective interventions for 1 of 1 resident (R29) who had a history of multiple falls and sustained fractures. This deficient practice resulted in immediate jeopardy for R29. The immediate jeopardy began on 6/12/17, when R29 had not been comprehensively assessed for the root cause of repeated attempts of self transfer and appropriate interventions implemented and was identified on 9/21/17. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 11:09 a.m. on 9/21/17. The immediate jeopardy was removed at 3:39 p.m. on 9/22/17, but noncompliance remained at the lower G scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include;	2 830	Corrected	

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2 830	Continued From page 7 Review of R29's signed Physician Order Sheet, signed 9/5/17, identified diagnoses which included dementia with behavioral disturbance, chronic obstructive pulmonary disease and recurrent major depression. R29's quarterly Minimum Data Set (MDS) dated 6/6/17, identified R29 had diagnoses which included dementia, osteoporosis and depression. The MDS listed R29 had severe cognitive impairment, and required extensive assistance with dressing, hygiene, toileting, transfers and locomotion. Further, the MDS identified R29 had a fall since the prior assessment. R29's significant change MDS dated 8/31/17, identified R29 had severe cognitive impairment, required extensive assistance with dressing, hygiene, eating and locomotion, total assistance with transfers, toileting and did not walk. The MDS identified they were unable to determine if R29 had a fall or fracture since the prior assessment. The MDS also identified R29 had no falls since the prior assessment. However, R29 had sustained a fall with major injury noted on 6/12/17, a fall with no injury on 7/8/17 and a fall with major injury on 8/20/17. R29's Fall Risk Care Area Assessment (CAA) dated 9/7/17, indicated R29 was at risk for falls. The CAA indicated R29 had a history of falls last quarter and her most recent fall was 8/20/17. The CAA further indicated R29 had sustained a left hip fracture from the fall. The CAA indicated R29 had recent return from hospital, therapy department was working with R29 and safety precautions remained in place. Staff were alert to R29's risk factors for fall potential.	2 830		

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2 830	Continued From page 8 R29's Fall Risk Assessment dated 9/7/17, identified R29 had a score of 24. The assessment indicated a resident whose score was over 9 was at risk for falls. No further Fall Risk Assessments were provided by facility. Review of R29's current care plan printed on 9/20/17, at 3:04 p.m., last updated 8/21/17, at 3:23 p.m., identified R29 had dementia, and was at risk for falls due to cognitive deficits. R29's care plan listed various interventions which included: use of a low bed, perimeter mattress, resident did not remember that she needed assistance with transfer or ambulate and directed to anticipate needs, inspect shoes/footwear for proper fit, reduced slip shoes, keep call light in easy reach, no skid strips in front of toilet, alarm on bathroom door to alert entering, gripper socks in bed, and safety bed/chair alarms and floor mat alarms for resident at all times. Review of the facility form titled NAR (nursing assistant registered) Care Sheet, dated 9/20/17, directed staff to use 2 staff for transfers, and safety devices included alarm BR (bathroom) door TABS and wanderguard. No further fall interventions were listed on the care sheet. On 9/19/17, at 11: 33 a.m. R29 was observed lying in her bed on her right side. Her bed was in a low position, and observed to have bilateral grab bars in place and a concave mattress. She had a colored mat located on the floor on the right side of her bed and a black pressure floor mat was present on the left side of her bed. She had a white rectangular box (TABS alarm unit) attached to the left grab bar on her bed, with a string running from the box to her shirt on her mid upper back.	2 830		

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2 830	Continued From page 9 On 9/20/17, at 2:17 p.m. R29 was observed lying in bed with the head of bed slightly elevated. The bed was in low position. Grab bars were observed in place and a concave mattress was on the bed. She had a TABS alarm unit attached to the left grab bar. The string from the unit was attached to her shirt with a metal clip on the front of her left shoulder. A black pressure floor mat alarm was in place on the left side of her bed, and a colored padded mat was on the floor on the right side of her bed. On 9/21/17, at 5:28 a.m. R29 was observed lying on her back with eyes closed in her bed. The bed was in low position and had a concave mattress. There was a black pressure floor alarm on the floor near the left side of her bed and a colored padded mat on the floor on the right side of her bed. The TABS alarm unit was attached to the left grab bar with a red cord leading from the tab unit to under her back. Review of R29's Incident Details/Fall Scene Investigation Reports from 11/29/16 to 9/18/17, revealed the following: -11/29/16, at 1:20 a.m. found on floor next to her bed, alert. The wheelchair was in front of her, brakes not on, and stockings were on her feet. The report identified R29 had socks on feet and slipped while attempting self transfer. The report indicated gripper socks were to be applied at bedtime, no alarms were utilized at the time of the fall, and no injury noted. An IDT (interdisciplinary team) meeting note dated 12/5/16, identified the root cause of fall was R29 self transferring and improper footwear. Gripper socks were applied to feet and maintenance was notified to place gripper strips next to the bed.	2 830		

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2 830	Continued From page 10 -11/29/16, at 10:20 p.m. found on the floor next to her bed. R29 was disorientated, incontinent of loose stool, stated she had been reaching for a stool, although she pointed to her nightstand. The report listed R29 had gripper socks on, and wore shoes on her feet. Staff were unaware when R29 had last toileted. An IDT meeting note dated 12/5/16, identified the root cause of fall was R29 self transferring and loose stools. Nurse to monitor BM pattern, move night stand closer to bed so resident able to reach from bed, TABS alarms applied. -12/4/16, at 2:07 p.m. staff heard a loud sound and found sitting on the floor in front of her nightstand. R29 was disorientated, stated "my wrist" and rubbed her wrist, no injury noted. Staff looked under her bed and retrieved a bracelet on the floor under the bed. The bracelet was placed on R29's wrist. An IDT meeting note dated 12/5/16, identified the root cause of the fall was R29 resident appeared to attempt to get bracelet that fell under her bed when lost balance and fell off of bed. Evaluation sent to therapy in regards to number of falls. -1/24/17, at 6:50 p.m. staff had been assisting roommate and noticed R29 on the floor in her room outside her bathroom. R29 was disorientated, appeared to attempt self transfer, wheelchair alarm had been unhooked from resident and not sounding. No injuries were noted and a pad alarm placed in her wheelchair. An IDT meeting note dated 1/30/17, identified the root cause of fall was R29 slipped out of wheelchair while attempting self transfer. R29 had removed TABS alarm from self. Pad alarm was placed in chair as R29 disabled the TABS alarm.	2 830		

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2 830	Continued From page 11 - 2/6/17, at 6:30 p.m. found sitting on the floor near the conference room, with her back leaning against a geri-chair. R29 was disorientated, wheelchair next to her, with brakes on. TABS alarm had been attached to resident, resident removed clip, alarm not sounding. No injury noted. The report identified R29 had self transferred to a geri-chair which was stored in front of the conference room. The geri-chair was removed from the common area and properly stored in the conference room with doors shut. No IDT meeting notes were found. -2/12/17, at 7:20 p.m. found on floor with her back against the wall, in her bathroom. R29's mental status was normal for her, and had fall while self transferring. She had removed the wheelchair alarm, which had been hooked on the back of her shirt. The report listed a secondary alarm on the bathroom floor, had not been activated by staff. R29 expressed some discomfort across her upper torso and chest area, and a chest x-ray completed on 2/13/17, revealed no acute findings. Staff educated on the use of the secondary alarm, toileting plan. An IDT meeting note dated 2/13/17, identified R29 had taken self to toilet and fell. TABS alarm was placed on bathroom door to alert staff of taking self to toilet. An addendum dated 9/20/17, (during survey) identified the care plan was not followed as bathroom door alarm had already been in place. The notes did not address how to deal with R29 removing alarms. -3/28/17, at 7:45 p.m. found on the floor in her room near her bed. R29 was disorientated, and indicated she was going to bed. No injury noted. No alarm was observed on her wheelchair at that time. Wheelchair alarm applied at that time. An IDT meeting note dated 4/3/17, identified R29	2 830		

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2 830	Continued From page 12 had been attempting to transfer self into bed and fell. The note indicated R29's care plan had been followed, the immediate intervention put in place was the use of a TABS alarm on the wheelchair to alert staff of any self transfer. However, R29's clinical record indicated the alarm on her wheelchair had been in place during R29's 1/24/17, 2/6/17, and 2/12/17 falls and a pad alarm had been placed on R29's wheelchair after R29's 1/24/17 fall. The note lacked any further documentation of analysis of R29's fall. -6/12/17, at 8:00 a.m. during a.m. cares R29 was disorientated, and complained of discomfort in her right shoulder with movement. A bruise on the top of her right clavicle region was noted, with swelling around the site. A scrape below her right knee was also noted. R29 winced with discomfort with movement of the area. The report indicated R29 reported, "I fell" and denied any assistance after the fall. The report listed staff were to use 2 for all transfers with a gait belt until after the portable x-ray was completed. The report indicated a portable x-ray done identified a fracture of her distal right clavicle. The record included written statements from staff dated which noted R29 had been assisted to bed at approximately 6:30 p.m. on 6/11/17 and had no visible bruises and no complaints of pain at that time. The staff statement indicated 5:00 a.m. rounds had been completed on 6/12/17 and she was sleeping at that time and no complaints of pain. A staff written statement, dated 6/13/17 indicated the staff member had assisted R29 with morning cares on 6/12/17. The statement indicated during cares, R29 had indicated her arm hurt and staff found bruises on her shoulder and front of her right leg. The record also included written statements from 6/13/17, which indicated R29's bed had been unable to be put in	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13 low position a week prior and maintenance personnel had been notified of the broken bed. Maintenance had determined new parts for the bed needed to be ordered, and adjusted the bed to the lowest position, and would remain in that position until the new part installed. The written statement from maintenance personnel dated 6/13/17 indicated he had set the bed in approximately 3 inches higher than the lowest position possible, ordered the needed parts for the bed and installed the parts on 6/13/17. An IDT meeting note dated 6/13/17, indicated R29 had been noted to have bruising and complaints of pain in her right shoulder during morning cares. The note indicated staff had asked R29 what happened and she had stated she fell and nobody had helped her get up. R29's care plan was revised to include 2 assist for transfers at that time. No documentation of further investigation of the cause of R29's injury was noted, no further analysis of the effectiveness/use or function of the safety devices in place had been completed. - 7/8/17, at 8:55 a.m. R29 was found lying on her side on the floor, in the doorway of another resident's bathroom. The report listed R29 had unhooked her alarm, gotten up without assistance, removed her shoes and TABS alarm and was in stocking feet. No injuries noted. A TABS alarm pressure pad was placed in her wheelchair to alert staff to her needs. An IDT meeting note dated 7/10/17, indicated R29 was found crawling on the floor outside of another resident's bathroom. The note indicated R29 had no injury, and care plan had been followed. The immediate intervention was for implementation of a pressure pad in her wheelchair to alert staff to self transfers. No further analysis of the fall was documented. However, R29's clinical record	2 830		

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	00668	A. BUILDING: _____ B. WING _____	09/22/2017

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2 830	Continued From page 14 indicated a pad alarm had been placed on R29's wheelchair after the 1/24/17 fall. Despite the facility having knowledge R29 repeatedly removed/unhooked alarms previously, analysis of R29's fall interventions and use of alarms had not been completed. -8/20/17, at 12:45 a.m. staff heard a noise and found R29 on the floor outside her room, with her walker in her room. R29 was disorientated and indicated she was going to close the door and "buff the floor." The report identified R29 had been observed earlier in the shift taking alarms off herself. R29 denied discomfort at that time. The report indicated staff were to place bed alarm out of resident sight and reach, so she would not take off the alarm or turn the alarm off. On 8/21/17, R29 indicated she had discomfort in her left leg and hip area, guarding of the area and was unwilling to transfer. A x-ray completed at that time, identified an acute intertrochanteric fracture of the left femur associated with 90 degrees varus angulation of the femoral shaft fragment. An IDT meeting note dated 8/22/17, identified staff noted that R29 had removed her TABS alarm earlier in the shift and was talking delusional and was unsettled earlier in the shift. The note indicated the immediate intervention was to reapply the TABS alarm and place where she could not remove it herself. The note indicated on 8/21/17, R29 had complained of left leg and hip pain, guarded leg and was unwilling to transfer. Further, the note indicated R29 had been transferred to the hospital for evaluation of a left hip fracture. The note indicated R29's care plan had been followed. No further analysis of R29's fall was documented. However, despite R29's repeated removal/unhook of alarms, no other interventions had been implemented prior to R29's fall on 8/20/17.	2 830		

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2 830	Continued From page 15 Review of R29's progress notes from 11/29/16 to 9/20/17, revealed the following: -11/29/16, at 1:30 a.m. R29 was found on floor, sitting next to bed, wheelchair in front of her, brakes not locked. Denied pain. Was in stocking feet, gripper socks applied. Maintenance notified to put down grippy strips next to her bed. Hourly checks tonight for safety. -11/29/16, at 10:29 p.m. R29 was found sitting on floor next to her bed. Was wearing gripper socks and shoes. Her wheelchair was behind her. Denied pain. R29 indicated she was reaching for stool, but pointed towards nightstand. Put back into bed, TABS alarm in place. -12/4/16, at 2:25 p.m. staff heard loud sound, found R29 on the floor in front of her nightstand. R29 indicated her wrist and rubbed it. Looked under bed and found bracelet, retrieved and placed bracelet on R29's wrist. No injury noted. -12/6/16, at 7:39 a.m. R29 identified as fall risk with safety interventions in place. Has had falls this quarter. Last fall 12/4/16. Grab bars and perimeter mattress used. -12/12/16, at 1:30 p.m. Therapy evaluation completed. R29 was appropriate for activity therapy services. Review of R29 identified she had multiple falls and review of safety interventions in place completed. -1/16/17, Discontinued from active therapy. Restorative AROM(active range of motion)/Toileting program to continue. -1/24/17, at 11: 58 p.m. R29 was found on the	2 830		

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2 830	Continued From page 16 floor outside the bathroom at 6:50 p.m. No injury noted. Placed a pad alarm on chair. Cause of fall identified alarm was on chair and unhooked. -2/6/17, at 7:23 p.m. R29 was found at 6:30 p.m. sitting on floor with back leaning against Geri-chair with wheelchair next to resident with brakes on. R29 had removed the clip from the alarm and it was not sounding. No injury noted. Geri-chair removed from common area and properly stored in conference room with doors shut. -2/12/17, at 10:56 a.m. R29 was found sitting on floor of bathroom. R29 had self transferred. R29 complained of chest pain and mid area sharp. Message left for primary physician. -3/13/17, at 1:35 p.m. R29 had falls in last quarter. Last fall was 2/12/17. Note indicated R29 had severe cognitive impairment with a BIMS score of 5. R29 has rolled out of bed in the last 3 months and a perimeter mattress is used. R29 has history of chest pain from previous fall. The follow up x-ray indicated no fracture. -3/20/17, at 4:31 p.m. note indicated R29 recognized objects and people, but did not recognize place, time or situation -5/21/17, at 1:49 p.m. note indicated a review of R29's safety devices was completed. Falls risk assessment indicated she was at risk for falls. Does wander in wheelchair. Is inconsistent in asking for help and does attempt independent transfer in and out of bed and chair. Currently using an alarm on bathroom door and alarms used in bed, wheelchair and lift chair. Toileting program remains in place. Will continue usage of alarms in plan of care.	2 830		

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2 830	Continued From page 17 -6/8/17, at 2:14 p.m. At risk for falls, R29 had had falls this quarter, last fall 3/28/17, and safety interventions in place. R29 has severe cognitive impairment and disorientated to time and place. Last noted fall from bed was 3/28/17, and R29 had a perimeter mattress in place. No changes to bowel and bladder assessment or interventions. No changes or updates to plan of care. -6/12/17, at 8:15 a.m. R29 grabbed and squeezed right shoulder winced and complained of pain. R29 had a bruise on top of her right clavicle region, swelling was noted around the site. A scrape was noted also below R29's right knee. R29 stated she fell when asked, and when asked if anyone helped her she shook her head no. R29's primary physician was notified and orders were received for a PPX (portable x-ray). Two staff assistance for R29 with all transfers and transfer belt until PPX completed. -6/12/17, at 7:59 p.m. results of x-ray indicated fracture of distal right clavicle. R29's primary physician was notified. -6/13/17, at 5:29 p.m. R29 had increased difficulty with transfers since incident. R29's primary physician was called and new orders received for clavicle strap to use as needed for comfort and physical therapy may evaluate and treat to direct safe transfers. -6/14/17, at 1:52 p.m. A care conference was held and 90 day assessments were completed. Assessment indicated falls, wanderguard, bed/chair/floor alarms, bed low, anti-roll backs. No further documentation related fall assessment documented.	2 830		

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2 830	Continued From page 18 -6/30/17, at 10:11 p.m. R29 was very anxious and attempting to get out the doors of the facility. Staff explained this was her home. -7/5/17, at 2:27 a.m. R29 was up in her wheelchair from 12:10 a.m. to 2:00 a.m. R29 had wheeled herself to the north and south doors and both times the alarm went off. -7/5/17, at 3:16 p.m. new order from primary physician to discontinue the clavicle strap, to do a follow up clavicle x-ray and for physical and occupational therapy to evaluate and treat for post clavicle fracture. -7/8/17, at 5:53 p.m. R29 was in another resident's bathroom doorway lying on her right side. R29 had removed her shoes and removed her TABS alarm. No injury noted. A TABS pressure alarm was placed in her wheelchair seat. Further, the note included "Remember, alarms do not prevent falls, they just alert staff to resident whereabouts, so if not alarming, is not included as care plan not being followed, therefore is not reportable." -7/12/17, at 11:55 a.m. R29 had declined in activity tolerance, strength, and transfers were more difficulty. R29 was unable to walk since recent fracture. Orders received for therapy to evaluate and treat. -7/26/17, at 10;14 a.m. Chest of drawers was secured to wall. Care plan was followed. -7/26/17, at 10:36 a.m. active therapy services discontinued and restorative program remained in place.	2 830		

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2 830	Continued From page 19 -8/16/17, at 5:38 a.m. R29 was in her wheelchair from 1:00 a.m. to 3:30 a.m. The note indicated R29 told the writer that the girl needs cough syrup, but she did not. R29 ambulated out to the lobby and watched TV for awhile. -8/19/17, at 7:15 p.m. R29 was attempting to get outside and her wanderguard alarm was going off. One to one visit completed and resident toileted. -8/20/17, at 12:00 a.m. R29 was setting off alarm on her bed. R29 was assisted to the bathroom then back to bed and alarms were activated. -8/20/17, at 12:30 a.m. R29's bed alarm was ringing and R29 informed staff that she had woodticks. Staff checked R29 and found no woodticks. Bed alarm and floor mat were activated. Call light was within reach. -8/20/17, at 12:45 a.m. staff heard a noise coming from R29's room. She was on the floor outside of her room and her walker was inside her room. R29 stated she was going to shut the door and buff the floor. R29 sustained a 2 centimeter bump on her head and denied discomfort. Ice was applied. R29 was assisted back to bed with assistance of 2 staff and gait belt. R29 was observed to unhook alarm at this time. Informed she needed to keep the alarm on and R29 continued to play with alarm buttons. Alarm moved out of reach of R29. -8/20/17, at 4:37 a.m. R29's bed and floor pad were on and not within reach. Denied any discomfort. -8/21/17, at 8:30 a.m. R29 complained of left hip pain when she was sitting in her wheelchair. R29	2 830		

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2 830	Continued From page 20 was guarding her left leg. R29's primary physician was notified, and orders for x-ray were received. -8/21/17, at 1:00 p.m. R29 was repositioned every 2 hours and was rolled to support her left leg. Ice was applied for comfort. R29 showed signs of pain with repositioning and guarded her left leg and hip area. -8/21/17, at 9:00 p.m. x-ray of pelvis and left hip. -8/21/17, at 10:00 p.m. x-ray results indicated fracture of left hip. R29's primary physician was notified. Orders for foley indwelling urinary catheter, to keep resident on bed rest, NPO (no oral intake) after midnight and to transfer for surgery in the morning. -8/25/17, at 4:15 p.m. R29 returned from hospital for left femur fracture and left hip fracture. New orders received, including PT (physical therapy) and OT (occupational therapy) to evaluate and treat. -8/26/17, at 6:11 a.m. R29 had left hip pinned on 8/23/17, PT evaluation 8/25/17. Hoyer lift for all transfers. -8/29/17, at 3:59 a.m. R29 exercised poor judgement and did not use call lights. Low bed, bed alarm, floor pad in place and activated. Call light was within reach. -8/30/17, at 9:00 a.m. care conference was completed and 90 day assessments were reviewed including R29's comprehensive report. Safety indicated falls, wanderguard, bed/chair/floor alarms,bed low, anti-rollbacks. No further documentation of a comprehensive	2 830		

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2 830	Continued From page 21 assessment of R29's falls was documented. -9/1/17, at 3:30 p.m. R29 had severe cognitive impairment. R29's health status had changed with recent hip fracture and pinning. R29 had experienced lethargy and poor appetite. -9/5/17, at 11:41 a.m. review of progress notes. On 9/5/17, at 8:50 a.m. has had falls this quarter, last fall 8/20/17, fall risk noted, safety interventions in place. Hoyer used for R29's transfers and she was unable to walk. R29 identified as at risk for falls. Staff noted fall risk potential as recent. -9/6/17, at 1:35 p.m. care conference held and 90 day assessments reviewed including Resident Comprehensive Report. Fall, wanderguard, bed/chair/floor alarms, bed low, anti-rollbacks. No further documentation of R29's fall assessment was documented. -9/8/17, at 3:15 p.m. PT evaluation completed and R29 appropriate for active therapy services. -9/13/17, at 9:00 p.m. comment added by registered nurse (RN)-A 9/20/17, at 2:12 p.m. on 9/13/17 (during survey) a review of R29's safety devices was completed during weekly PPS-modifications made as directed. -9/19/17, at 4:04 a.m. R29 was restless and trying to climb out of bed. R29 was assisted up to the wheelchair with extensive assistance of 2 staff. R29 refused to go to the bathroom at that time. Acetaminophen 325 mg X 2 tablets were given to the resident for right hip and leg pain. R29 was unable to rate pain, and her incision site was dry and intact. R29 was given pudding for a snack.	2 830		

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2 830	Continued From page 22 -9/20/17, at 4:36 p.m.(during survey) R29's safety devices currently in place were reviewed by IDT. Note indicated to continue to problem solve to meet her safety needs. Staff interview indicated R29 was not actively pulling at alarm strings/devices. R29's plan of care was modified to meet her needs. R29 was being seen by active therapy services. Screen was to be sent to therapy to review current safety device/interventions in place and aide with problem solving to meet R29's needs. During interview on 9/20/17, at 1:39 p.m. NA-A indicated the last time she was aware R29 attempted to take the alarm off was several weeks ago, "maybe a month or two ago." On 9/20/17, at 2:02 p.m. NA-D indicated staff utilized a TAB alarm in her bed and wheelchair for R29 and she also had an alarm on her bathroom door. She stated R29 did not use her call light. She indicated R29 was at risk of falls. She indicated R29 had removed her alarms in the past, but was not aware of her doing it lately. On 9/20/17, at 2:19 p.m. NA-E indicated R29 utilized a TAB alarm connected to her bed or wheelchair which staff clipped to the back of her shirt. She indicated R29 had not tried to remove her alarm in awhile. She indicated the facility had added a pressure floor mat alarm after her fracture. R29 utilized a cushioned pad on the floor on the side near the window, but she had never seen her get out of bed on that side. On 9/20/17, at 2:38 p.m. NA-C indicated staff watched R29 for falls. He indicated R29 utilized a TAB alarm and indicated he was aware R29 self	2 830		

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2 830	Continued From page 23 transferred. He indicated R29 attempted to self transfer at least once a day, and the most recent time he was aware of R29's self transfer was the last evening at approximately 7:00 p.m., when he heard the floor alarm pad sound. NA-C indicated he did not feel R29 could remove the TAB alarm herself. On 9/20/17, at 2:49 p.m. during group interview with RN-A and licensed practical nurse (LPN)-A, RN-A indicated LPN-A completed fall assessments for the facility. RN-A indicated her last fall risk assessment had been completed on 9/7/17, and she scored 24, and a score of anything over 9 indicated the resident was at risk of falls. RN-A stated R29 had fallen in June and broke her clavicle and fractured her hip with her most recent fall. She indicated the facility had made many changes to R29's care plan because staff needed to provide much more assistance to R29. RN-A indicated the facility reviewed falls routinely in a weekly therapy meeting which she identified as a interdisciplinary meeting. At that time, interventions were reviewed and changes were made as needed. RN-A indicated the facility documented the meeting in a IDT note in each resident's chart. However, the fall scene investigation forms and IDT meetings failed to comprehensively assess R29's risk for falls to include but not limited to trends/patterns to falls, factors that may be causing the falls, and effectiveness of interventions. On 9/20/17, at 3:04 p.m. LPN-A indicated after R29's clavicle fracture the facility had increased staff to 2 assist with ADLs (activities of daily living) and the floor pressure alarm had been added after her hip fracture. RN-A confirmed R29	2 830		

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2 830	Continued From page 24 had severe cognitive impairment, history of hallucinations and indicated she felt R29 was a reliable historian related to the incident when R29's clavicle fracture was found. RN-A indicated she felt R29 was right on and sometimes she was not and felt her cognitive status was intermittent. RN-A indicated she felt R29 could still communicate effectively. LPN-A indicated she was aware R29 had a history of removing her alarm and continued to remove her alarms. RN-A indicated she felt R29 would not be candidate for 1 hour checks, and she had no consistency with toileting patterns in the past. RN-A stated staff were in R29's room a lot, because of her roommates condition, but the facility had never put in a formal program for R29 safety checks. On 9/20/17, at 4:16 p.m. director of nursing (DON) confirmed R29's current care plan and indicated her care plan should of been updated to include applying the TABS alarm in a place where she could not remove it when this was discussed on 8/22/17. The DON confirmed it also should have been updated on the NAR care sheet. During review of R29's electronic health record with surveyor, the DON stated there were inconsistencies with the computer data related to the placement of the clip for the alarms and was unable to explain the inconsistencies. At 4:29 p.m. DON stated she had been made aware of revisions to the care plan made at that time, and felt that was the reason for the inconsistencies. She indicated she assumed the intervention related to placement of the clip for alarm was removed because it was no longer effective. During follow up interview at 4:39 p.m. DON indicated licensed staff had talked with staff and found out R29 had no longer tried to remove her alarm, so she felt that intervention was no longer	2 830		

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2 830	Continued From page 25 needed. She confirmed R29 was restless, but indicated she felt she had not tried to remove her alarm or self transfer. DON stated she was not aware of the self transfer attempt documented in R29's medical record on 9/19/17. On 9/21/17, at 5:31 a.m. RN-B stated R29 was sometimes restless at night and indicated R29 had slept very well at present. RN-B felt R29 had slept better last night because her roommate was out of the room during the night. RN-B indicated the roommate would make noise and wake up R29. RN-B indicated she had not witnessed R29 try to self transfer since her fractured hip, but she indicated she was aware other staff had reported R29 continued to attempt self transfers since her fractured hip. She indicated she had witnessed R29 attempt to self transfer approximately one week prior, when she assisted R29 to put her legs back into bed. She stated R29 had dementia and indicated R29 at times would understand what staff say to her and at other times not. RN-B indicated the last time she was aware R29 attempted self transfer was earlier that night when a nursing staff informed her of the self transfer. RN-B indicated R29 utilized a floor alarm, TABS alarm and she indicated the facility staff checked her frequently. RN-B stated the facility had implemented hourly checks last night and stated R29's floor alarm had been in place for a few months, but was unsure exactly how long it had been utilized. RN-B indicated she was aware R29 knew how to take her TABS alarm off and that she had shut off the pressure floor alarm. She indicated R29 took the TABS alarm off herself every other day or every third day. RN-B indicated R29 was confused at times, was difficult to know if she understood and indicated that was her normal state.	2 830		

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2 830	Continued From page 26 On 9/21/17, at 5:54 a.m. trained medication aide (TMA)-A indicated R29 utilized a TABS alarm and indicated R29 always took it off. She indicated R29 had been able to remove the clip of the TABS alarm, from wherever it was placed. TMA-A indicated R29 also had a pressure floor alarm and stated the alarms had been in place a long time, and the floor pressure alarm on the floor had been used for R29 6 months or more. TMA-A indicated she also had a door alarm on her bathroom to alert staff also. TMA-A indicated R29 had confusion and communicated in only a few words. TMA-A stated R29 sometimes tried to get up on her own, and she could get herself onto the edge of the bed. On 9/21/17, at 5:46 a.m. NA-G indicated R29 was confused, utilized a floor pressure alarm, which had been in place prior to the fractured hip. She indicated she was not aware R29 had attempted self transfer since she had her hip fracture. On 9/20/17, at 6:00 a.m. NA-H stated R29 was confused andhe was aware R29 had attempted self transfer the night before, when she had indicated she saw a girl running around and wanted to get up and find her. He stated he had been assisting R29's roommate when this occurred. NA-H stated the alarm had not sounded yet, but saw her attempting to get up and last night was the most recent self transfer attempt he was aware of. On 9/21/17, 6:38 a.m. LPN-A indicated the usual facility practice when a resident fell was for the charge nurse to assess the resident for injury,and if injury was present she would address the injury. She then would look at the environment for determining cause for fall, the root cause and put immediate interventions in place. She indicated	2 830		

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2 830	Continued From page 27 on Mondays the facility held therapy/IDT meetings and falls were reviewed at the meetings and documentation of the meetings were done. LPN-A confirmed she was responsible for completion of the fall assessments and LPN-A stated the facility completed comprehensive fall assessments for admissions, annually, hospital returns and change of conditions. She indicated she had assisted with the investigation of R29's incident on 6/12/17, which resulted in the clavicle fracture. She indicated another nurse had interviewed R29 and R29 was able to answer questions at that time. LPN-P indicated therapy was initiated, a clavicle brace was utilized and assistance of 2 staff for transfers were contained. She stated R29 had another fall on 7/8/17, and stated a pressure alarm was placed in R29's wheelchair at that time. LPN-A indicated R29 was confused at times and verified R29 was delusional earlier on the shift of 8/20/17. LPN-A indicated she thought the pressure floor alarm was initiated when R29 returned from the hospital. After review of R29's progress note dated 8/20/17, at 12:30 a.m. with surveyor, she confirmed the pressure floor alarm was in place prior to the fall on 8/20/17. . On 9/21/17, at 7:01 a.m. NA-I indicated R29 was a little confused, and had a TABS alarm in place for as long as she worked at facility and thought the pressure floor mat had been implemented since she broke her hip. She confirmed the current NAR care sheet did not include use of the tabs alarm or specific directions on how to place the alarm. NA-I indicated she had not witnessed R29 self transfer since she broke her hip. She indicated prior to that, R29 would attempt self transfer at least once a day. On 9/21/17, at 7:16 a.m. RN-A confirmed R29's	2 830		

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2 830	Continued From page 28	2 830		

printed NAR care sheet dated 9/20/17 and confirmed R29's current care plan, printed 9/20/17. She indicated she had made changes to both the previous evening. RN-A confirmed she had talked with R29 after she was noted to have bruises on her shoulder and indicated R29 had told her she "fell", and had not asked for help and no one assisted her and it was hard for her to get up. She indicated she felt the cause of the bruising on R29 was from the reported fall.

On 9/21/17, at 7:37 a.m. DON stated her usual practiced was to document minutes of the IDT meetings for specific residents in the incident report. She indicated she maintained a log of incidents reviewed at the meetings, on a form titled BVHC Therapy meeting and confirmed documentation of a review of R29 after the 6/12/17 fall had not been done and confirmed R29 had been reviewed in the meeting after her 7/8/17 and 8/20/17 falls. At 8:00 a.m. DON stated R29 unhooking her alarm, footwear, toileting status and medical status was found to be the cause of R29's 7/8/17 fall. She confirmed R29 was found on the floor on 8/20/17 after staff had noted earlier she was removing her alarms and was confused. DON indicated the immediate intervention implemented at that time was to attach the TABS alarm in a place she could not remove herself. She verified no further interventions were implemented at that time. The DON stated the usual facility practice was for the charge nurse to complete an incident report and staff involved were to complete witness statements of the incident. The DON was notified, determined if the incident was a reportable event.

On 9/21/17, at 8:05 a.m. the DON indicated the usual facility practice for falls was for LPN-A to complete the comprehensive fall assessments,

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2 830	Continued From page 29	2 830		

and the MDS coordinator reviewed the assessments and completed the care plans. She indicated a charge nurse would complete the incident report, utilized the fall investigation form to gather information for the report and then the IDT would review the fall at the routine meetings. She indicated the IDT would review the information sooner if needed. DON confirmed R29's current care plan and NAR care sheets. She confirmed R29 had removed the alarms herself on 7/8/17 and 8/20/17.

On 9/21/17, at 1:54 p.m. RN-A confirmed the comprehensive fall assessment done with the significant change MDS CAA on 9/7/17. She indicated she had reviewed R29's comprehensive fall assessments with DON and was unable to provide any further comprehensive fall assessments completed for R29.

Review of primary physician's progress notes from 6/2/17 to 9/2/17 revealed the following:

-6/2/17, R29 not very talkative but she denied chest pain or stomach pain, no back pain, no trouble breathing.

-7/8/17, R29 had fallen today, but was not hurt. Her x-ray indicated nondisplaced fracture of the distal end of the clavicle and that is ok.

-8/2/17, R29 complaint was she was tired.

-9/2/17; R29 was back from having her hip pinned. Her review of systems really not reliable because she does not respond much, but apparently no problems.

Review of Prairie Lakes Healthcare System hospital discharge summary, history and physical

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2 830	Continued From page 30 from R29's hospital stay from 8/22/17, to 8/25/17 revealed the following: -Prairie Lakes Healthcare System history and physical dated 8/22/17; indicated review of systems unobtainable due to the patient's dementia. Due to the patient's dementia, risks, benefits and alternatives were discussed but unsure if the patient is truly understanding anything at this stage. -Prairie Lakes Healthcare System discharge summary dated 8/25/17, She does have chronic dementia, so unfortunately is limited on what she will answer when we ask he questions. Review of the facility policy titled St. Francis Health Services of Morris Accident/Incident reviewed and amended on 4/16/15 identified guidelines and procedures that adequately identify, assess, treat and prevent accidents and incidents that put the resident at risk for injury. The policy directed the IDT team to determine the root cause(s) of the incident, the best approaches to prevent reoccurrence and identify trends and patterns. A fall risk assessment would be completed upon admission, hospital returns, significant change of condition, if falls are triggered, on a 90 day review, annual review and any time a restraint was applied. As soon as possible, within 48-72 hours the Interdisciplinary team would complete the care center accident/incident follow up form to further assess probable causes of the incident and make any further recommendations. Once the assessment and causes have been completed, the interventions that were implemented by the nursing and or interdisciplinary team will be evaluated for effectiveness, and any other new interventions will be implemented. If not follow up	2 830		

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2 830	Continued From page 31 was necessary, it can be documented on the follow up section on the form. If follow up was necessary this would be done by the IDT in approximately a week from the date the team assessment was completed. If follow up is required sooner than a week, this would be documented on the form as well. If the quality assurance team identifies significant causes or trends, measures will be taken to correct the identified areas. The immediate jeopardy that began on 6/12/17, was removed on 9/22/17, when the facility comprehensively assessed R29 for falls, implemented effective interventions and revised the facility fall policies to include a fall analysis to be completed after 2 or more falls to determine trends and revise the care plan as needed. Intervention changes made for R29 included: Celexa put on hold, vitamin D added, hipsters, hourly checks between 8 p.m. and 8 a.m. and a tracking log for alarm activations for R29. R29's toileting plan was also revised to include scheduled toileting during the night hours. The non compliance remained at the lower scope and severity of G, isolated, and actual harm had occurred to R29. SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) could provide inservice training to nursing staff on the importance of re-assessment after a resident has experienced a fall. An audit could be developed to ensure the appropriate assessment and interventions are implemented to ensure resident safety. The results could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one	2 830		

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2 830	Continued From page 32 (21) days.	2 830		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure a clean and sanitary environment was maintained for 2 of 4 resident rooms observed to have overflowing garbage's. Findings Include: On 9/19/17, at 9:52 a.m. a shared bathroom for residents R10 and R42, was observed to have a garbage pail overflowing with soiled incontinent products. An odor of urine was also observed to linger in the bathroom. On 9/20/17, at 8:41 a.m. nursing assistant (NA)-E indicated the facility NA's were not responsible for removing the garbage's in resident rooms when they were full. NA-E stated the facility housekeeping staff was responsible for removing residents garbage's when full. On 9/21/17, at 12:53 p.m. housekeeping (H)-A indicated resident rooms were cleaned every day, which included removing garbage in the bathroom. H-A indicated housekeeping staff were	21695	Corrected	10/27/17

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21695	Continued From page 33	21695		

present in the facility Monday through Friday and only during day time hours. H-A indicated when housekeeping were not present in the facility, NA's were responsible to collect soiled garbage and remove the garbage from resident rooms. H-A further indicated when she would arrive in the early morning hours, she would routinely find R10's and R42's shared bathroom garbage overflowing with soiled incontinent products. H-A indicated in the past R42 had reported to her that her shared bathroom garbage was routinely overflowing with soiled briefs. H-A further indicated she had encouraged R42 to not pick up the soiled products from the floor and to let facility staff know if the garbage required changing before or after housekeeping arrived.

R42's quarterly Minimum Data Set, dated 9/16/17, identified R42 had intact cognition.

On 9/21/17, at 1:25 p.m. R42 indicated her shared bathroom garbage with R10 was routinely overflowing with soiled incontinent products. R42 stated she used to pick up the soiled products up from the bathroom floor when they would fall off of the pile, however she had been told not to pick them up and was directed to notify nursing staff. R42 stated she had spoken with a nurse, nurses assistant and activities, as recently as a few weeks ago, about her concern with the overflowing garbage and nothing had changed. R42 stated often times the soiled incontinent products would carry a strong odor of urine, which she could smell in her room. R42 further stated the evening staff routinely would not remove the soiled incontinent products from her bathroom, and the garbage would stay until the following morning.

On 9/21/17, at 1:31 p.m. environmental services

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21695	Continued From page 34 director (ED) indicated to his understanding if there were soiled incontinent products in residents rooms, it was the facility NA's who were responsible to remove the soiled garbage's when housekeeping staff were not in the facility. ED stated this would need to be on the evening and night shifts. ED further stated housekeeping would empty resident garbage's once a day and only more if requested by staff or residents. On 9/21/17, NA-K stated her usual shift to work was the evening shift and her usual process would be to check residents garbage's at the end of the shift, prior to residents going to bed. NA-K further indicated she would often not check R10 and R42's shared bathrooms, as both residents were independent with activities of daily living. On 9/21/47, at 3:51 p.m. NA-C indicated he worked all shifts and he would not routinely check garbage's on the south end of the building, which included R10 and R42's rooms and bathroom. NA-C indicated he would remove any soiled garbage's after he assisted residents with cares, however; residents who were independent with cares would not have their garbage's checked and changed at the end of the shift. On 9/22/17, at 1:40 p.m. the director of nursing (DON) stated she would expect staff to clean up all residents rooms at the end of the shift to ensure the removal of soiled incontinent products, this would include R10 and R42's shared bathroom. On 9/22/17, at 1:41 p.m. the social service designee/activity director indicated she was unaware R42 had concerns with her bathroom garbage.	21695		

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21695	Continued From page 35 On 9/22/17, at 2:30 p.m. the admissions coordinator indicated facility nursing staff had been told not to enter residents rooms to remove garbage's if the residents were sleeping. She further indicated there was not a current process in place to remove soiled incontinent products from resident rooms which were independent in cares, that included R10 and R42. An undated facility policy titled, Odor Elimination Policy, revealed it was the policy of the facility upon receiving a complaint regarding orders, steps would be taken to eliminate the odors. The policy did not address maintaining an odor free resident environment. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies on removal of trash from the resident's environment timely to prevent foul odors and educate staff on those policies. An audit could be developed to ensure the environment remains odor free. The results could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		10/27/17

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21805	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a dignified dining experience for 3 of 3 residents (R4, R5, R29) who required assistance with eating during the supper meal on 9/18/17 in the dining room. Findings include: On 9/18/17, at 5:04 p.m. R4 was seated in a black and purple tilt in space (adjustable reclining) wheelchair positioned at the table with her meal in front of her. R29 was to the left of R4, seated in her wheelchair at the table with her meal in front of her. To the left of R29 was an empty chair and then R5 was seated in a black tilt in space wheelchair, reclined at a 45 degree angle. R5 had her meal in front of her, but her eyes were closed and she was breathing through her mouth. Next to R5 was nursing assistant (NA)-I. NA-I was seated in a chair, leaning her elbow on the table as she fed R4 spoonfuls of food, not talking with any of the residents. At 5:11 p.m. NA-I remained seated at the table with R4, R29 and R5. NA-I was leaned over the table on her elbows, leaning to the right side, and offered spoonfuls of food to R4. She did not talk, or engage R4 in conversation while she assisted her to eat, and did not talk or engage R29 or R5 during the meal. At 5:19 p.m., R29 coughed, NA-I stood up and walked over to R29 and offered her a glass of water. NA-I sat back down next to R4, resumed offering bites of food to R4. NA-I did not talk to R4 and did not engage her in conversation.	21805	Corrected	

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21805	Continued From page 37 At 5:22 p.m. NA-B approached the dining room table and sat next to R5 and called her name once. R5 did not open her eyes or respond to NA-B rubbing the top of her right leg. R5's wheelchair remained tilted at a 45 degree angle, NA-B did not attempt to adjust R5's wheelchair to an upright position and no further attempts from NA-B to wake R5. NA-B then turned to R29 and offered a bite of food. At 5:33 p.m., NA-I remained seated, leaning on the table with her elbows, feeding bites of food to R4. R29 continued to independently take bites of food and R5 remained seated in tilt in space wheelchair at a 45 degree angle with eyes closed. NA-I and NA-B did not talk or engage R4, R5, R29 in conversation. NA-B left the table and NA-F sat down at the table between R29 and R5. At 5:39 p.m. R5 remained seated at a 45 degree angle in wheelchair with eyes closed and mouth open. NA-I placed a spoonful of eggs into R5's mouth without attempting to wake her or encourage her to eat. NA-I used spoon to push the eggs to the back of R5 mouth to get a swallow response. NA-I repeated pushing the eggs to the back of her mouth until R5 swallowed. NA-I did not talk to R5, and R5 did not open her eyes. NA-I and NA-F talked with eath other, and discussed their individual hours of work schedule. At 5:41 p.m. NA-I and NA-F continued to discuss their work schedules. NA-I discussed her sleep schedule at home with NA-F, and discussed child's issues at home with NA-F. No engagement with R4, R29 or R5 was observed. NA-I continued to assist R4 with bites of food while talking with NA-F. At 5:52 p.m. R4, R29 and R5 remained seated at	21805		

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	00668	A. BUILDING: _____ B. WING _____	09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNS VALLEY HEALTH CENTER	114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219

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21805	Continued From page 38	21805		

the table with NA-I and NA-F. NA-F and NA-I continue to carry on a personal conversation between themselves, no attempts to engage the residents in conversation were observed.

At 6:02 p.m. R4 and R29 were assisted to leave the dining room.

On 9/18/17, at 7:45 p.m. NA-F confirmed she had been seated next to R5 during the supper meal. NA-F stated she felt R4, R5 and R29 kept to themselves at meals and confirmed she and NA-I continued in personal conversation with each other throughout the supper meal.

On 9/21/17, at 2:46 p.m. NA-I confirmed she had assisted R4, R29 and R5 with the supper meal on 9/18/17. She confirmed she had a personal conversation throughout the entire supper meal with NA-F and had not engaged the residents in conversation. She indicated she was aware this was not a dignified experience for R4, R5 or R29. NA-I confirmed, staff had received reminders in the past to limit personal conversations while assisting residents with their meals.

On 9/21/2017, at 2:56 p.m. director of nursing (DON) confirmed staff not engaging with residents during meal times was not acceptable practice. She indicated facility staff had been educated on assisting with meals and dignity in the past.

Review of the undated policy titled Browns Valley Health Center Dignity Policy ,indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.

SUGGESTED METHOD OF CORRECTION: The

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21805	Continued From page 39 director of nurses (DON) could provide inservice training to nursing staff on the importance of providing a dignified dining experience to all residents. An audit could be developed to ensure staff are conducting appropriate conversations with residents during meal times while providing assistance. The results could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of	21980		10/27/17

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21980	Continued From page 40 known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report injuries of unknown source and potential neglect of care to the State agency for 1 of 3 (R29) residents reviewed for abuse/neglect/neglect of care. R29 sustained an injury of unknown source that was not reported within 24 hours, and then when staff became aware of a fracture failed to report within 2 hours. R29 also sustained a fractured hip following a fall where fall interventions were not in place, and the facility failed to report potential neglect of care within 2 hours when aware of the fracture. In addition, the facility failed to implement policy for	21980	Corrected	

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21980	Continued From page 41	21980		

completion of a thorough investigation for 1 of 1 resident (R29) reviewed with a injury of unknown origin with serious bodily injury.

Findings Include:

Review of R29's signed Physician Order Sheet, signed 9/5/17, identified diagnoses which included dementia with behavioral disturbance, chronic obstructive pulmonary disease and recurrent major depression.

R29's quarterly Minimum Data Set (MDS) dated 6/6/17, identified R29 had diagnoses which included dementia, osteoporosis and depression. The MDS listed R29 had severe cognitive impairment, and required extensive assistance with dressing, hygiene, toileting, transfers and locomotion. Further, the MDS identified R29 had a fall since the prior assessment.

R29's significant change MDS dated 8/31/17, identified R29 had severe cognitive impairment, required extensive assistance with dressing, hygiene, eating and locomotion, total assistance with transfers, toileting and did not walk.

R29's current care plan printed on 9/20/17, at 3:04 p.m. last updated 8/21/17, at 3:23 p.m. by registered nurse (RN)-A identified R29 had a potential for abuse. The care plan also indicated R29 was at risk for falls or injury related to cognitive deficits and required assistance with activities of daily living (ADL)s. The care plan further indicated R29 did not remember that she needed assistance with transfer or ambulation, and instructed staff to anticipate her needs.

Review of R29's Incident Details/Fall Scene Investigation Report from 6/12/17, revealed the

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21980	Continued From page 42 following: -6/12/17, at 8:00 a.m. during a.m. cares R29 was disorientated, and complained of discomfort in her right shoulder with movement. A bruise on the top of her right clavicle region was noted, with swelling around the site. A scrape below her right knee was also noted. R29 winced with discomfort with movement of the area. The report indicated R29 reported, "I fell" and denied any assistance after the fall. The report listed staff were to use 2 for all transfers with a gait belt until after the portable x-ray was completed. The report indicated a portable x-ray done identified a fracture of her distal right clavicle. The record included written statements from staff dated which noted R29 had been assisted to bed at approximately 6:30 p.m. on 6/11/17, and had no visible bruises and no complaints of pain at that time. The staff statement indicated 5:00 a.m. rounds had been completed on 6/12/17, and she was sleeping at that time and no complaints of pain. A staff written statement dated 6/13/17, indicated the staff member had assisted R29 with morning cares on 6/12/17. The statement indicated during cares, R29 had indicated her arm hurt and staff found bruises on her shoulder and front of her right leg. The record also included written statements from 6/13/17, which indicated R29's bed had been unable to be put in low position a week prior and maintenance personnel had been notified of the broken bed. Maintenance had determined new parts for the bed needed to be ordered, and adjusted the bed to the lowest position, and would remain in that position until the new part installed. The written statement from maintenance personnel dated 6/13/17, indicated he had set the bed in approximately 3 inches higher than the lowest position possible, ordered the needed parts for	21980		

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21980	Continued From page 43	21980		

the bed and installed the parts on 6/13/17. An IDT meeting note dated 6/13/17, indicated R29 had been noted to have bruising and complaints of pain in her right shoulder during morning cares. The note indicated staff had asked R29 what happened and she had stated she fell and nobody had helped her get up. R29's care plan was revised to include 2 assist for transfers at that time. No documentation of further investigation of the cause of R29's injury was noted, no further analysis of the effectiveness/use or function of the safety devices in place had been completed.

Review of R29's progress notes revealed the following:

-6/12/17, at 8:15 a.m. R29 grabbed and squeezed right shoulder winced and complained of pain. R29 had a bruise on top of her right clavicle region, swelling was noted around the site. A scrape was noted also below R 29's right knee. R29 stated she fell when asked, and when asked if anyone helped her she shook her head no. R29's primary physician was notified and orders were received for a PPX (portable x-ray). Two staff assistance for R29 with all transfers and transfer belt until PPX completed.

-6/12/17, at 7:59 p.m. results of x-ray indicated fracture of distal right clavicle. R29's primary physician was notified.

Review of submission to Office of Health Facility Complaints (OHFC) identified the report had been submitted on 6/13/17, at 1:07 p.m.

Review of R29's investigation summary of the 6/12/17, incident revealed on 6/12/17, during a.m. cares NAR (nursing assistant registered) staff

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21980	Continued From page 44 indicated R29 complained of pain in her right shoulder area and noted a bruise and swelling at the top of the right clavicle region. When asked, R29 stated she fell, and then went on to say that she did not ask for help and that nobody had assisted her, and it was hard to get herself back up. An x-ray completed at 7:59 p.m. revealed a fracture of the distal right clavicle. The care plan at the time of incident was followed. Review of R29's Incident Details/Fall Scene Investigation Report 8/20/17, revealed the following: -8/20/17, at 12:45 a.m. staff heard a noise and found R29 on the floor outside her room, with her walker in her room. R29 was disorientated and indicated she was going to close the door and "buff the floor." The report identified R29 had been observed earlier in the shift taking alarms off herself. R29 denied discomfort at that time. The report indicated staff were to place bed alarm out of resident sight and reach, so she would not take off the alarm or turn the alarm off. On 8/21/17, R29 indicated she had discomfort in her left leg and hip area, guarding of the area and was unwilling to transfer. A x-ray completed at that time, identified an acute intertrochanteric fracture of the left femur associated with 90 degrees varus angulation of the femoral shaft fragment. An IDT meeting note dated 8/22/17, identified staff noted that R28 had removed her TABS alarm earlier in the shift and was talking delusional and was unsettled earlier in the shift. The note indicated the immediate intervention was to reapply the TABS alarm and place where she could not remove it herself. The note indicated on 8/21/17, R29 had complained of left leg and hip pain, guarded leg and was unwilling to transfer. Further, the note indicated R29 had	21980		

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21980	Continued From page 45	21980		

been transferred to the hospital for evaluation of a left hip fracture. The note indicated R29's care plan had been followed. No further analysis of R29's fall was documented. However, despite R29's repeated removal/unhook of alarms, no other interventions had been implemented prior to R29's fall on 8/20/17.

Review of R29's progress notes revealed the following:

-8/20/17, at 12:45 a.m. staff heard a noise coming from R29's room. She was on the floor outside of her room and her walker was inside her room. R29 stated she was going to shut the door and buff the floor. R29 sustained a 2 centimeter bump on her head and denied discomfort. Ice was applied. R29 was assisted back to bed with assistance of 2 staff and gait belt. R29 was observed to unhook alarm at this time. Informed she needed to keep the alarm on and R29 continued to play with alarm buttons. Alarm moved out of reach of R29.

-8/21/17, at 8:30 a.m. R29 complained of left hip pain when she was sitting in her wheelchair. R29 was guarding her left leg. R29's primary physician was notified, and orders for x-ray were received.

-8/21/17, at 10:00 p.m. x-ray results indicated fracture of left hip. R29's primary physician was notified. Orders for foley catheter, to keep resident on bed rest, NPO (no oral intake) after midnight and to transfer for surgery in the morning.

Review of submission to OHFC identified the report had been submitted on 8/22/17, at 8:55 a.m.

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21980	Continued From page 46 Review of R29's investigation summary of the 8/20/17, incident revealed on 8/20/17, at 12:45 a.m. staff heard a noise coming from the proximity of R29's room. Staff observed her outside her room on the floor. R29 indicated to the staff she was going to close the door so that she could buff the floor. Was noted earlier in the shift to be restless and had some delusional behaviors. R29 denied pain at that time. The next day she complained of pain, and an x-ray was completed at 9:30 p.m. and revealed a left hip fracture. The care plan at the time of incident was followed. During interview on 9/20/17, at 12:56 p.m. with the administrator and director of nursing (DON), the administrator confirmed the current facility policy and stated the facility had 24 hours to report to SA. She stated she was aware of the requirement for 2 hour reporting for serious injury and confirmed the facility's current policy reflected that time requirement. At 12:58 p.m. the DON stated the usual practice was to report immediately, no later than 24 hours to SA. She stated she was not aware of the requirement to report cases of serious injury within 2 hours of knowledge. She confirmed the findings for R29 from 8/20/17, was a serious injury, and it had not been reported within 2 hours of knowledge of the injury. At 1:45 p.m. the administrator stated she had reviewed R29's fall on 6/12/17, with the staff members involved, and the staff had felt because R29 could tell them she fell, the incident did not meet the requirements for unknown injury to be reported in 2 hours. On 9/20/17, at 3:04 p.m. during interview with registered nurse (RN)-A and licensed practical nurse (LPN)-A , RN-A confirmed R29 had severe	21980		

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21980	Continued From page 47 cognitive impairment, and history of hallucinations. She indicated she felt R29 was a reliable historian related to the incident when R29's clavicle fracture was found. RN-A indicated she felt R29 was right on and sometimes she was not and felt her cognitive status was intermittent. RN-A indicated she felt R29 could still communicate effectively. On 9/21/17, at 7:16 a.m. RN-A confirmed she had talked with R29 after she was noted to have bruises on her shoulder and indicated R29 had told her she "fell", and had not asked for help and no one assisted her and it was hard for her to get up. She indicated she felt the cause of the bruising on R29 was from the reported fall. The facility policy titled, St Francis Health Services of Morris Skilled Nursing Facility Maltreatment Reporting Guidelines, reviewed/amended 11/18/16, included each care center must report to the state agency (OHFC) any suspected maltreatment, which included injuries of unknown source immediately, but not later than 2 hours if result in serious bodily injury. SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) could provide inservice training to nursing staff on the requirement of timely reporting to the State agency of a major injury, and implementation of the facility's abuse prohibition policy. An audit could be developed to ensure the required components of the facility's abuse prohibition policy is consistently implemented. The results could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Fourteen	21980		

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21980	Continued From page 48 (14)- days.	21980		

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	245564	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/19/2017**

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BROWNS VALLEY HEALTH CENTER	**114 JEFFERSON STREET SOUTH** **BROWNS VALLEY, MN 56219**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Browns Valley Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/11/2017

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.

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BROWNS VALLEY HEALTH CENTER	**114 JEFFERSON STREET SOUTH** **BROWNS VALLEY, MN 56219**

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K 000	Continued From page 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Browns Valley Health Care is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1970 and was determined to be of Type II(111) construction. In 2001 an addition was added to the north that was determined to be of Type II(111) construction and is protected by a fire sprinkler system. Because the original building and the addition are of the same type construction, meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected and the	K 000		

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	245564	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/19/2017**

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K 000	Continued From page 2 sprinkler system is installed in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems. The facility has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 41 beds and had a census of 41on the day of the survey.	K 000		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		10/27/17

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K 321	Continued From page 3 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This **STANDARD** is not met as evidenced by: Based on observation and staff interview the facility failed to construct 2 hazardous rooms in accordance with the 2012 Life Safety Code, (NFPA 101) section 19.3.2.1.3. This deficient practice could allow for smoke or fire to enter the corridor making it untenable for exiting, affecting 4 of the 41 residents and an undetermined amount of staff and visitors. Findings include: At 9:17 am and 9:21 am on 09/19/2017 observations and staff interview revealed self closer's were missing from the oxygen storage room in the east wing and the housekeeping storage room in the east wing. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services .	K 321	K321 - Housekeeping closet and Secondary O2 room will have closure devices installed by on or before 11/1/17 Andy Raw.	
K 341 SS=D	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed	K 341		10/5/17

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K 341	Continued From page 4 at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 4 of the 41 residents and an undetermined amount of patients, staff and visitors. Findings include: At 9:24 am on 09/19/17 observations and staff interview revealed a smoke detector in the east wing next to the cross corridor doors was within 36 inches of an HVAC diffuser. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services .	K 341	K341 - HVAC Diffuser was moved further than 36 inches away from smoke detector by Andy Raw on 10/5/17	
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		9/28/17

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K 345	Continued From page 5 Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain the smoke detection system as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.1.5 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, section 14.3.1. This deficient condition could delay alarm notification in case of a fire and affect all 41 residents and an undetermined amount of staff and visitors. Findings include: At 8:29 am on 09/19/17 documentation review and staff interview revealed an inspection of the fire alarm has not been conducted within the last 12 months. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services .	K 345	K345 – Fire Alarm inspection has been completed by NARDINI FIRE under supervision by Andy Raw on 9/28/17, next inspection date will be monitored by Andy Raw. Inspection dates will be reviewed on a monthly basis going forward.	
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		10/9/17

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K 353	Continued From page 6 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of staff and visitors. Findings include: At 10:23 am on 09/19/17 observations and staff interview revealed the sprinkler head in the lower level elevator machine room had joint compound on it. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services .	K 353	K353 – NOVA SPRINKLER was called in to replace a sprinkler head with Joint Compound on it in the elevator maintenance closet, upon further inspection "Adam" with nova sprinkler indicated that it was not joint compound but factory paint to indicate that it was a high temp (212 degree) sprinkler head and will therefore not be replaced. Was inspected on 10/09/2017	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie	K 372		10/5/17

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K 372	Continued From page 7 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of three smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 30 of the 41 residents and an undetermined amount of staff and visitors. Findings include: At 9:30 am on 09/19/17 observations and staff interview revealed a penetration in the smoke barrier in the north wing above the cross corridor doors did not have the proper fire stopping in the end of the conduit. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services .	K 372	K372 – Conduit above smoke barrier has been stopped up with proper fire rated caulking by Andy Raw and a check for additional conduit has been conducted on 10/5/17	
K 521 SS=B	NFPA 101 HVAC HVAC	K 521		10/4/17

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K 521	Continued From page 8 Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain proper exhaust throughout all resident wings as required by the 2012 Life Safety Code (NFPA 101) section 9.2.2 and NFPA 91 Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids. This deficient practice could negatively affect 34 of the 41 residents and an undetermined amount of staff and visitors. Findings include: At 9:15 am and 9:33 am on 09/19/17 observations and staff interview revealed the resident room bathroom fans in the east and north wings were not operable. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services .	K 521	K521 – Bathroom Exhaust Units were inspected and repaired on 10/4/17 by Andy Raw, Bath Fans will be monitored on a monthly basis by Andy Raw	
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept	K 711		10/5/17

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K 711	Continued From page 9 informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a Fire Safety Plan as required in NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. This deficient practice could cause confusion in an emergency and affect all 41 residents and an undetermined amount of staff and visitors. Findings include: At 8:20 am on 09/19/17 documentation review and staff interview revealed the Fire Safety Plan does not clearly address all 9 items listed in the Life Safety Code. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services .	K 711	K711 – Fire & Evacuation plans have been updated to include required missing data by Andy Raw on 10/5/17	