DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 30, 2021

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: May 13, 2021

Dear Administrator:

On June 29, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Electronically delivered
June 3, 2021

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: May 13, 2021

Dear Administrator:

On May 13, 2021, a survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 ePoC 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. 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 August 13, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by November 13, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431**

(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 On 5/11/21, through 5/13/21, a standard abbreviated survey was conducted at your facility. Your facility was NOT found to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5119018C (MN72614). A dieficiency was issued at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		6/25/21

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

Electronically Signed | 06/11/2021

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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F 684	Continued From page 1 Based on interview and document review, the facility failed to identify a fracture following a fall for 1 of 3 residents (R1) reviewed for falls. Findings include: R1's Admission Record printed 5/13/21, identified R1 had diagnoses including heart failure, reduced mobility and weakness. R1's quarterly Minimum Data Set (MDS) dated 3/9/21, indicated R1 had intact cognition In addition, R1 required extensive assistance of one staff with transfers and toileting. On 5/3/21, at 6:49 a.m. a progress note indicated R1 was found on her floor in her room on her left side. The note indicated R1 told nursing staff that she was okay, denied hitting her head and her range of motion (ROM) was intact. The note further indicated the administrator and R1's MD had also been notified. On 5/4/21, at 6:45 a.m. a progress note completed by trained medication aide (TMA)-A indicated R1 required medication to be administered for pain control. The progress note lacked severity, location of pain, or any pain assessment. On 5/4/21, at 8:12 p.m. a progress note completed by licensed practical nurse (LPN)-A indicated R1 pain had been relieved by medication. The progress note lacked severity, location of pain, or any pain assessment. On 5/5/21, at 4:56 a.m. a progress note completed by registered nurse (RN)-B indicated R1 had not displayed any signs or symptoms of	F 684	F684 Quality of Care R1 received treatment and care for a fracture on 5/6/21. All residents that fall have the potential to be affected by a deficient practice in this area. All residents with falls in the last month were reviewed for documentation of nursing assessments and follow up on findings after a fall. Nurse training on findings to be complete by 6/4/21. Falls policy reviewed and revised PRN. Re-education provided to all Nursing staff on the falls policy and the post-fall nursing assessment process, including adequate documentation of finding, by 6/18/21. Re-education was completed with nurse who wrote inaccurate documentation immediately upon finding of the documentation. DON will complete random audits of post-fall nursing assessments/documentation to ensure inclusion of skin condition and site and severity of pain 3x/week for 2 weeks, then 2x/week for 2 weeks, then weekly thereafter to ensure adequate post-fall nursing assessments are being complete and followed up on appropriately. Audit results will be brought to QAPI Committee for review and further recommendations.	

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F 684	Continued From page 2	F 684		

discomfort from the fall on 5/3/21. The note further indicated R1's ROM was intact, and R1 was using Tylenol for pain management when needed.

R1's progress notes lacked indication of pain, bruising or swelling in her left arm from 5//3/21, through 5/5/21.

On 5/6/21, at 9:00 a.m. a progress note completed by RN-A indicated R1's left upper arm was completely bruised from front to back, and down to the elbow. The bruising was noted to be a dark blue-purple to black in color. R1's arm was noted to be very edematous, with pitting edema all the way to her fingertips. R1 had stated the bruising began after her fall on 5/3/21. The progress note further indicated per R1's nurse practitioner (NP)-A, R1's arm was significantly more swollen than the day prior. R1's orders to included in-house X-ray of the left arm, as well as compression sleeve and glove.

On 5/6/21, at 9:46 a.m. a progress note documented by NP-A indicated R1 was seen on the morning of 5/6/21, related to a follow-up for a recent fall. R1 had been seen by NP-A on 5/5/21, for a follow-up on lab work, and at that time was noted to have mild left-hand swelling following a fall that had occurred early morning on 5/3/21. R1 had declined an x-ray on 5/5/21, and was agreeable to an occupational therapy/physical therapy (OT/PT) evaluation, and if no improvement would consider an x-ray. During physical exam on 5/6/21, R1's swelling to her left arm was noted to have increased significantly. R1 had agreed to NP-A removing her long-sleeved sweatshirt. Bruising was noted to extend from her left shoulder to left elbow, as well as across her

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F 684	Continued From page 3	F 684		

left chest. R1 complained of pain in particular with any raising of her arms. R1 was able to move her fingers and her wrist at that time. R1 agreed to have an x-ray completed in-house.

On 5/6/21, at 3:57 p.m. a progress note indicated per NP-A, R1's was to be sent to the hospital to be seen by orthopedics.

On 5/6/21, at 10:52 p.m. a progress note indicated R1 had returned to the facility at approximately 8:00 p.m. via ambulance on stretcher. R1's left arm was in a sling. Orders included left arm sling and a follow up with orthopedics to be scheduled

R1's After Visit Summary discharge orders dated 5/6/21, identified R1 had a closed nondisplaced fracture (skin closed and bone has not moved out of alignment) of the proximal end of left humerus (long upper arm bone). Orders included left arm sling to be in place continually, and follow up with orthopedics in 2-5 days.

On 5/12/21, at 7:44 a.m. R1 was interviewed and stated she had fallen earlier in the week when she was reaching for something in her closet. R1 stated the wheelchair came out from under her, and landed on her shoulder. R1 stated her left arm hurt continually since her fall, and she had let staff know of the increased pain. R1 stated NP-A had wanted her to go out for a x-ray, but she wanted to have the x-ray done in the facility instead of going out. R1 stated she did agree to go out to the clinic after the x-ray revealed a fracture.

On 5/12/21, at 10:53 a.m. nursing assistant (NA)-A was interviewed and stated she had

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F 684	Continued From page 4	F 684		

worked with R1 following the fall on 5/3/21. NA-A stated R1 had complained about arm/shoulder pain when transferring using the EZ-stand (mechanical lift) during toileting assist. NA-A stated she thought she had reported R1's complaint of pain to the TMA or the nurse. NA-A stated she did not recall looking at R1's left arm while providing toileting assistance.

On 5/12/21, at 9:24 a.m. NA-B was interviewed and stated she had worked with R1 following the fall on 5/3/21, both the afternoon and night shift as well as dayshift on 5/5/21. NA-B stated R1 often refused to let the staff change her clothing and always wore long sleeves, so she had not noticed bruising of her left arm. NA-B stated she only assisted R1 with toileting, and R1 had told her that her arm hurt. NA-B stated she reported this to the nurse working.

On 5/12/21, at 9:42 a.m. TMA-A was interviewed and stated she had worked on R1's unit on 5/4/21, and 5/5/21. TMA-A stated staff had not reported anything different related to R1's arm, and she had not looked at R1's arm. TMA-A stated if staff had come to her, she would have reported this to the charge nurse on duty.

On 5/12/21, at 10:53 a.m. NA-D was interviewed and stated she had worked with R1 on 5/3/21, 5/4/21, 5/5/21, and 5/6/21. NA-D stated after R1's fall, her hand was slightly swollen, but had gradually gotten much worse. NA-D stated she had not personally looked at R1's arm or shoulder since R1 always had a long sleeve shirt on. NA-D stated she had reported R1's hand looked swollen, and she had been complaining about pain to the nurse.

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F 684	Continued From page 5	F 684		

On 5/12/21, at 11:00 a.m. LPN-A stated she worked on R1's unit on 5/4/21, and 5/5/21, and didn't see anything out of the ordinary. LPN-A stated she assisted the staff completing the in-house x-ray, and she recalled seeing light grey bruising and mild swelling. LPN-A stated she had not completed any assessment of R1's arm on 5/4/21, or 5/5/21.

On 5/12/21, at 11:21 a.m. RN-A stated she had not been aware of an injury to R1 until 5/6/21, when NP-A had alerted the director of nursing (DON) and herself about R1's left arm injury. RN-A stated R1's left arm/shoulder was bruised dark purple, R1's arm and hand was swollen. RN-A stated she had not completed ROM at that time due to a possible fracture. RN-A stated R1 was able to move her fingers, but was not able to move her arm. RN-A stated R1 had agreed at that time to have an x-ray done in-house, and she was ultimately sent to the emergency room (ER) to be evaluated for a fracture.

On 5/13/21, at 9:00 a.m. NP-A was interviewed. NP-A stated on 5/5/21, she had gone to see R1 related to a follow up on labs that had previously been drawn, and to look at a wound on her leg. NP-A stated R1 had reported to her that she had fallen. NP-A stated the facility had not made her aware of the fall, and NP-A then requested the fall sheet from the facility. NP-A stated R1's left hand was swollen, and she notified the DON. NP-A stated R1 had been wearing a long sleeve sweater, and she did not remove the sweater to inspect the arm at that time. NP-A stated R1 refused to go into the ER at that time. NP-A stated the following day on 5/6/21, she returned to the facility and went to see R1. R1 had increased swelling to her left hand. NP-A stated a

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F 684	Continued From page 6	F 684		

full exam was completed, and bruising was noted from R1's shoulder to her elbow, and across her chest. NP-A stated R1 had agreed at that time to have an x-ray completed, and was ultimately sent to the emergency room (ER) to be evaluated for fracture. NP-A stated she would have expected the facility to identify the change in condition, and to have notified her.

On 5/13/21, at 9:51 a.m. the DON was interviewed and stated she was not made aware of the extent of R1's injury until NP-A had notified her personally. The DON stated when she looked at R1's arm, there was no way the nurse's could have been documenting accurately. The DON stated the nurse's follow-up documentation and assessments were not acceptable, and R1's injury should have been identified, and documentation should have reflected such.

The facility policy Accident/Incident revised 1/8/18, directed St Francis Health Services will establish guidelines and procedures that adequately identify, assess, treat, and prevent accidents and incidents that put the resident at risk for injury.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2021

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

Re: State Nursing Home Licensing Orders
Event ID: G1J811

Dear Administrator:

The above facility was surveyed on May 11, 2021 through May 13, 2021 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

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

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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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: On 5/11/21, through 5/13/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT found to be in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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	00002	A. BUILDING: _____ B. WING _____	C 05/13/2021

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2 000	Continued From page 1 SUBSTANTIATED: H5119018C (MN72614). A licensing order was issued at 4658.0520 Subp1 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 surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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 interview and document review, the facility failed to identify a fracture following a fall for 1 of 3 residents (R1) reviewed for falls. Findings include: R1's Admission Record printed 5/13/21, identified R1 had diagnoses including heart failure, reduced mobility and weakness. R1's quarterly Minimum Data Set (MDS) dated 3/9/21, indicated R1 had intact cognition In addition, R1 required extensive assistance of one staff with transfers and toileting.	2 830	F684 Quality of Care R1 received treatment and care for a fracture on 5/6/21. All residents that fall have the potential to be affected by a deficient practice in this area. All residents with falls in the last month were reviewed for documentation of nursing assessments and follow up on findings after a fall. Nurse training on findings to be complete by 6/4/21. Falls policy reviewed and revised PRN. Re-education provided to all Nursing staff on the falls policy and the post-fall nursing assessment process, including adequate documentation of finding, by	6/25/21

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2 830	Continued From page 3 On 5/3/21, at 6:49 a.m. a progress note indicated R1 was found on her floor in her room on her left side. The note indicated R1 told nursing staff that she was okay, denied hitting her head and her range of motion (ROM) was intact. The note further indicated the administrator and R1's MD had also been notified. On 5/4/21, at 6:45 a.m. a progress note completed by trained medication aide (TMA)-A indicated R1 required medication to be administered for pain control. The progress note lacked severity, location of pain, or any pain assessment. On 5/4/21, at 8:12 p.m. a progress note completed by licensed practical nurse (LPN)-A indicated R1 pain had been relieved by medication. The progress note lacked severity, location of pain, or any pain assessment. On 5/5/21, at 4:56 a.m. a progress note completed by registered nurse (RN)-B indicated R1 had not displayed any signs or symptoms of discomfort from the fall on 5/3/21. The note further indicated R1's ROM was intact, and R1 was using Tylenol for pain management when needed. R1's progress notes lacked indication of pain, bruising or swelling in her left arm from 5//3/21, through 5/5/21. On 5/6/21, at 9:00 a.m. a progress note completed by RN-A indicated R1's left upper arm was completely bruised from front to back, and down to the elbow. The bruising was noted to be a dark blue-purple to black in color. R1's arm was noted to be very edematous, with pitting edema	2 830	6/18/21. Re-education was completed with nurse who wrote inaccurate documentation immediately upon finding of the documentation. DON will complete random audits of post-fall nursing assessments/documentation to ensure inclusion of skin condition and site and severity of pain 3x/week for 2 weeks, then 2x/week for 2 weeks, then weekly thereafter to ensure adequate post-fall nursing assessments are being complete and followed up on appropriately. Audit results will be brought to QAPI Committee for review and further recommendations.	

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2 830	Continued From page 4 all the bruising began after her fall on 5/3/21. The progress note further indicated per R1's nurse practitioner (NP)-A, R1's arm was significantly more swollen than the day prior. R1's orders to included in-house X-ray of the left arm, as well as compression sleeve and glove. On 5/6/21, at 9:46 a.m. a progress note documented by NP-A indicated R1 was seen on the morning of 5/6/21, related to a follow-up for a recent fall. R1 had been seen by NP-A on 5/5/21, for a follow-up on lab work, and at that time was noted to have mild left-hand swelling following a fall that had occurred early morning on 5/3/21. R1 had declined an x-ray on 5/5/21, and was agreeable to an occupational therapy/physical therapy (OT/PT) evaluation, and if no improvement would consider an x-ray. During physical exam on 5/6/21, R1's swelling to her left arm was noted to have increased significantly. R1 had agreed to NP-A removing her long-sleeved sweatshirt. Bruising was noted to extend from her left shoulder to left elbow, as well as across her left chest. R1 complained of pain in particular with any raising of her arms. R1 was able to move her fingers and her wrist at that time. R1 agreed to have an x-ray completed in-house. On 5/6/21, at 3:57 p.m. a progress note indicated per NP-A, R1's was to be sent to the hospital to be seen by orthopedics. On 5/6/21, at 10:52 p.m. a progress note indicated R1 had returned to the facility at approximately 8:00 p.m. via ambulance on stretcher. R1's left arm was in a sling. Orders included left arm sling and a follow up with orthopedics to be scheduled	2 830		

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2 830	Continued From page 5 R1's After Visit Summary discharge orders dated 5/6/21, identified R1 had a closed nondisplaced fracture (skin closed and bone has not moved out of alignment) of the proximal end of left humerus (long upper arm bone). Orders included left arm sling to be in place continually, and follow up with orthopedics in 2-5 days. On 5/12/21, at 7:44 a.m. R1 was interviewed and stated she had fallen earlier in the week when she was reaching for something in her closet. R1 stated the wheelchair came out from under her, and landed on her shoulder. R1 stated her left arm hurt continually since her fall, and she had let staff know of the increased pain. R1 stated NP-A had wanted her to go out for a x-ray, but she wanted to have the x-ray done in the facility instead of going out. R1 stated she did agree to go out to the clinic after the x-ray revealed a fracture. On 5/12/21, at 10:53 a.m. nursing assistant (NA)-A was interviewed and stated she had worked with R1 following the fall on 5/3/21. NA-A stated R1 had complained about arm/shoulder pain when transferring using the EZ-stand (mechanical lift) during toileting assist. NA-A stated she thought she had reported R1's complaint of pain to the TMA or the nurse. NA-A stated she did not recall looking at R1's left arm while providing toileting assistance. On 5/12/21, at 9:24 a.m. NA-B was interviewed and stated she had worked with R1 following the fall on 5/3/21, both the afternoon and night shift as well as dayshift on 5/5/21. NA-B stated R1 often refused to let the staff change her clothing and always wore long sleeves, so she had not noticed bruising of her left arm. NA-B stated she only assisted R1 with toileting, and R1 had told	2 830		

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2 830	Continued From page 6	2 830		

her that her arm hurt. NA-B stated she reported this to the nurse working.

On 5/12/21, at 9:42 a.m. TMA-A was interviewed and stated she had worked on R1's unit on 5/4/21, and 5/5/21. TMA-A stated staff had not reported anything different related to R1's arm, and she had not looked at R1's arm. TMA-A stated if staff had come to her, she would have reported this to the charge nurse on duty.

On 5/12/21, at 10:53 a.m. NA-D was interviewed and stated she had worked with R1 on 5/3/21, 5/4/21, 5/5/21, and 5/6/21. NA-D stated after R1's fall, her hand was slightly swollen, but had gradually gotten much worse. NA-D stated she had not personally looked at R1's arm or shoulder since R1 always had a long sleeve shirt on. NA-D stated she had reported R1's hand looked swollen, and she had been complaining about pain to the nurse.

On 5/12/21, at 11:00 a.m. LPN-A stated she worked on R1's unit on 5/4/21, and 5/5/21, and didn't see anything out of the ordinary. LPN-A stated she assisted the staff completing the in-house x-ray, and she recalled seeing light grey bruising and mild swelling. LPN-A stated she had not completed any assessment of R1's arm on 5/4/21, or 5/5/21.

On 5/12/21, at 11:21 a.m. RN-A stated she had not been aware of an injury to R1 until 5/6/21, when NP-A had alerted the director of nursing (DON) and herself about R1's left arm injury. RN-A stated R1's left arm/shoulder was bruised dark purple, R1's arm and hand was swollen. RN-A stated she had not completed ROM at that time due to a possible fracture. RN-A stated R1 was able to move her fingers, but was not able to

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2 830	Continued From page 7 move her arm. RN-A stated R1 had agreed at that time to have an x-ray done in-house, and she was ultimately sent to the emergency room (ER) to be evaluated for a fracture. On 5/13/21, at 9:00 a.m. NP-A was interviewed. NP-A stated on 5/5/21, she had gone to see R1 related to a follow up on labs that had previously been drawn, and to look at a wound on her leg. NP-A stated R1 had reported to her that she had fallen. NP-A stated the facility had not made her aware of the fall, and NP-A then requested the fall sheet from the facility. NP-A stated R1's left hand was swollen, and she notified the DON. NP-A stated R1 had been wearing a long sleeve sweater, and she did not remove the sweater to inspect the arm at that time. NP-A stated R1 refused to go into the ER at that time. NP-A stated the following day on 5/6/21, she returned to the facility and went to see R1. R1 had increased swelling to her left hand. NP-A stated a full exam was completed, and bruising was noted from R1's shoulder to her elbow, and across her chest. NP-A stated R1 had agreed at that time to have an x-ray completed, and was ultimately sent to the emergency room (ER) to be evaluated for fracture. NP-A stated she would have expected the facility to identify the change in condition, and to have notified her. On 5/13/21, at 9:51 a.m. the DON was interviewed and stated she was not made aware of the extent of R1's injury until NP-A had notified her personally. The DON stated when she looked at R1's arm, there was no way the nurse's could have been documenting accurately. The DON stated the nurse's follow-up documentation and assessments were not acceptable, and R1's injury should have been identified, and documentation should have reflected such.	2 830		

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2 830	Continued From page 8 The facility policy Accident/Incident revised 1/8/18, directed St Francis Health Services will establish guidelines and procedures that adequately identify, assess, treat, and prevent accidents and incidents that put the resident at risk for injury. SUGGESTED METHODS OF CORRECTION: The Director of Nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure staff are assessing residents after falls. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		