DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 21, 2023

Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, MN 56359

RE: CCN: 245127
Cycle Start Date: June 27, 2023

Dear Administrator:

On August 1, 2023, we notified you a remedy was imposed. On September 19, 2023 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 24, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 27, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 12, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 27, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 24, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 21, 2023

Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, MN 56359

Re: Reinspection Results
Event ID: Q9LV12

Dear Administrator:

On September 19, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 17, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2023

Revised Letter

Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, MN 56359

RE: CCN: 245127
Cycle Start Date: June 27, 2023

Dear Administrator:

This letter, sent on August 1, 2023, will replace the letter dated July 28, 2023. The effective date of the remedy of DDPNA, should be September 27, 2023.

On July 12, 2023, we informed you that we may impose enforcement remedies.

On July 17, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 27, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 27, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 27, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 27, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mille Lacs Health System will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 27, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division 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 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 December 27, 2023 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 28, 2023

Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, MN 56359

RE: CCN: 245127
Cycle Start Date: June 27, 2023

Dear Administrator:

On July 12, 2023, we informed you that we may impose enforcement remedies.

On July 17, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

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As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 28, 2023

Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, MN 56359

Re: State Nursing Home Licensing Orders
Event ID: Q9LV11

Dear Administrator:

The above facility was surveyed on July 14, 2023 through July 17, 2023 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(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 7/14/23 and 7/17/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51273573C (MN00095183), with no deficiencies issued. However, as a result of the investigation, a deficiency was issued at F689. 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		8/24/23

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

Electronically Signed | 08/02/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(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 689	Continued From page 1 Based on interview and document review, the facility failed to comprehensively assess fall risk and implement individualized interventions to reduce the risk of falls for 1 of 3 residents (R3) reviewed for accidents. This resulted in R3 falling 18 times since his January 2023 admission. Findings include: R3's admission Minimum Data Set (MDS), dated 1/12/23, identified R3 admitted to the facility on 1/5/23. He was moderately cognitively impaired and received limited physical assist with ambulation, transfers, and toileting. He was frequently incontinence of bladder. Diagnoses included dementia with behavioral disturbances, benign prostatic hypertrophy (BPH - enlarged prostate), and macular degeneration (eye condition impacting central vision). In addition, the MDS identified R3 fell prior to admission and utilized bed and chair alarms daily. R3's quarterly MDS, dated 4/13/23, identified R3 was severely cognitively impaired and received supervision with ambulation, transfers, and toileting. He was occasionally incontinent of bladder. Diagnosis included dementia with behavioral disturbances. In addition, the MDS identified R3 fell two or more times with no injury and two or more times with non-major injury and utilized bed and chair alarms daily. R3's Fall Risk Assessment, dated 1/5/23, identified a score of 14 (moderate risk). The assessment indicated R3 was free of falls prior to admission; however, at risk due to medication usage, occasional bladder incontinence, poorly fitted shoes, exhibited short discontinuous steps and/or shuffled steps and instability during turns,	F 689	The deficiency will be corrected through the following POC. For the residents who have been affected by the deficient process, the facility will complete the following: - Update care plan with resident centered fall interventions and will be completed by the IDT team members including the DON, care coordinator, Activities department, and Social worker. - Repeat the Fall Risk Assessment to identify residents specific risk factors - Update Primary Care Physician with risks identified. The facility will identify other residents who may have been, or may have the potential to be affected by the same deficiency: - Identify other residents with increased falls by reviewing fall records and present information at the falls meeting - Complete updated Fall Risk Assessment for those residents - Update care plans for those residents with resident centered fall interventions The facility will implement the following measures to ensure the deficient practice will not recur. - Update Monthly Falls Meetings to incorporate root cause analysis; this will involve MLHS Quality Department; Next meeting will be held on 8/16/23 and will include IDT members (Administrator, DON, Care Coordinators, SW, Quality, Activities) - In addition to current policy, a fall risk assessment will be done after a resident has two falls in one week. - Comprehensive analysis section added	

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F 689	Continued From page 2 and the required need for assistive device to walk. R3 was free of systolic blood pressure drops of 20mmHG or more between lying and standing (orthostatic hypotension). The assessment lacked a comprehensive fall risk analysis based on the identified information. R3's admission MDS driven Fall Care Area Assessment (CAA), dated 1/17/23, identified R3 fell on 12/20/22 while at the hospital. He was unsteady on his feet and declined to use the PT recommended walker and thus utilized a wheelchair (w/c) for locomotion and to transfer. Upon admission, therapy recommended he required stand by assist (SBA) for mobility. R3 was diagnosed with dementia with behaviors and currently utilized antipsychotic medications. Additional diagnoses included cardiac condition, anemia, and BPH. He maintained bowel control; however, was incontinent of bladder and was found to have an enlarged prostate and started on medication while in the hospital. He was offered toileting every two hours and upon his request. Hearing loss was present, and he did not wear hearing aids. Pain management was in place due to history of headaches and back pain. Due to edema (swelling) he wore a slip-on shoe. Adequate vision was assessed; however, vision loss reported in right eye. R3 required a motion sensor pad on bed, w/c, and recliner and he was free of significant drops in orthostatic blood pressure. The fall risk assessment indicated a moderate fall risk. The CAA indicated staff would proceed to care plan for interventions to minimize risk factors. The CAA lacked evidence staff completed a comprehensive fall assessment analysis or individualized intervention(s) identification based on R3's fall risk.	F 689	to fall risk assessments - Fall Policy will be updated to reflect the changes indicated - Staff education on falls and importance of fall scene investigations will be completed through mandatory staff meetings being held on 8/17/23 and 8/24/23. If staff cannot attend due to casual status, LOA, or vacation/illness, they will be assigned a mandatory training with competency. In order to monitor continued compliance, the following programs and systems will be put in place: - Complete audits weekly x 6 weeks to identify any residents with increased falls during that time period and the Fall Risk Assessment is getting completed. - If fall Scene Investigation is not being completed properly, corrective action will be done which will include coaching and/or corrective discipline. - Monthly audits x 3 months to ensure Fall Meetings completed monthly	

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F 689	Continued From page 3 R3's care plan identified the following information: -On 1/19/23, a Vulnerable Adult Focus was initiated with a goal he would remain safe while he lived at the facility. -On 1/23/23, a Potential for Falls Focus was initiated related to "altered mobility, vision, medication, edema, past history of falls, incontinence" with a revised goal on 2/6/23 to remain free of fall related injury. The following interventions were implemented: medication monitoring for adverse reactions and continued need, encouragement of feet elevation and appropriate footwear use, follow mobility, vision, and toileting care plans, keep frequently used items within reach and room free of clutter, motion sensor pad on bed, w/c, and in recliner. -On 1/23/23, an Alteration in Toileting/Elimination Focus was initiated and directed staff to offer R3 the toilet every two hours and upon request. -On 1/24/23, an Alteration in Mobility Focus was initiated related to weakness and dementia and identified R3 required 1 staff for ambulation and transfers. -On 4/26/23, the Potential for Falls Focus was revised to include anti-rollback brakes on w/c. -On 7/14/23, the Alteration in Cognition Focus, was revised and identified R3 had dementia with behaviors and displayed impaired safety awareness and decision making, along with short- and long-term memory changes. R3's subsequent progress notes and facility provided Fall Scene Investigation Reports (FSI) identified the following information: -On 1/8/23, R3 self-transferred repeatedly and required reminders to use the call light, frequent safety checks, redirection, and assist with toileting needs. -On 1/9/23, R3 removed the alarm sensor pad	F 689		

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F 689	Continued From page 4 out of his w/c on two separate occasions, self-transferred and required one-on-one supervision. -On 1/13/23, R3 self-transferred to the toilet and stated he had to go, or he was going to have an accident. -On 1/18/23, R3 attended a care conference with his family. Due to his self-transfers, bed and chair alarms were used. The note lacked information related to any additional fall intervention discussion. -On 1/19/23, R3 lost his balance and slowly lowered himself to the floor next to his bed. A FSI was not provided. -On 1/21/23 and 1/22/32, R3 "constantly" self-transferred/toileted. -On 1/24/23 at 7:20 p.m., R3 was seated on his buttocks in front of the bed. The alarm failed to sound. He stated he forgot to lock his w/c breaks. His conversation was confused but at baseline. Neurological (neuro) assessment was within normal limits (WNL). The FSI indicated the alarm failed as R3 turned it off. The Falls Team Meeting Notes embedded within the FSI identified the fall was reviewed on 1/25/23 in which a maintenance request was submitted for anti-rollback brakes on 1/24/23, prior to the fall, which had yet to be completed. -On 1/25/23, R3 complained of upper neck and bilateral shoulder pain which he stated, "happened awhile back when he fell in the bathroom." -On 1/26/23, R3 removed his alarms and turned them off on numerous occasions. Staff intercepted R3 when he self-transferred. He "nearly missed" the w/c and landed on the arm rest. A FSI was not provided. -On 2/2/23, R3 was seated on the bathroom floor next to the toilet. He sustained a "moderate" sized	F 689		

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F 689	Continued From page 5 abrasion to his right hip and complained of right sided temple tenderness. Neuro assessment was WNL. -On 2/3/23, neuros were performed on R3 in which his right pupil was a 2 in size and had no reaction to light and his left pupil was a 3 in size and reacted briskly to light. R3 received a right eye injection that morning during an appointment. A FSI report was not provided. -On 2/5/23, R3 was found lying on his bedroom floor. The alarm sounded. He stated he was reaching under the bed for his remote. He denied falling. A FSI was not provided. -On 2/11/23 at 6:55 a.m., R3 was seated on the floor with his head on the bed. The alarm sounded. He stated he was unsure where he was or what he tried to do. His w/c was pointed to the door and unlocked. "Pupils were 2mm (millimeters) sluggish." A follow-up note on 2/11/23, indicated right pupil was 2mm sluggish and left pupil was 3mm reactive. A FSI report identified R3 wore "flip flops," the w/c was unlocked, and he stated his "eyes were not working." In addition, the rear w/c wheel anti-lock brake failed to work. The team meeting note, dated by the director of nursing (DON) on 3/29/23, identified the w/c was repaired. -On 2/13/23, R3 walked in his room without walker or chair. The alarm sounded. When staff "grabbed" at his pants to help him, he attempted to hit staff and "almost fell." -On 3/26/23 at 11:30 p.m., R3 eloped from the facility and ran down a sidewalk away from staff who chased him. He stepped off a sidewalk curb. The momentum lunged him forward onto the pavement. R3 exhibited hallucinations when staff reached him. He sustained abrasions to his right 5th finger, right knee, right elbow, left calf, left palm, and required added support for transfers	F 689		

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F 689	Continued From page 6 for the hours that proceeded the fall. The FSI's team meeting notes, undated, indicated a medication (unidentified) was increased. -On 4/6/23 at 6:30 p.m., R3 was seated on his bedroom floor. Socks and sandals were on. He stated he hit his head and neuros were at his baseline. The alarm sensor pad sat on his bedside table. Staff replaced the sensor pad back in w/c. The FSI indicated R3 was "slightly more confused than baseline." The teams meeting note, undated, remained blank; however, team member signatures were present. R3's Fall Risk Assessment, dated 4/11/23, identified a score of 23 (high risk) related to multiple falls over the last six months, medication usage, occasional bladder incontinence, experienced orthostatic hypotension, poorly fitted shoes, exhibited short discontinuous steps and/or shuffled steps instability during turns, and the required need for assistive device to walk. The assessment lacked a comprehensive fall risk analysis based on the identified information. R3's care plan lacked revision(s) based on the fall risk assessment and R3's increased fall risk score. R3's subsequent progress notes and facility provided FSI reports identified the following information: -On 4/24/23 at 8:30 p.m., R3 was seated on the television room floor in front of his w/c. Alarm functioned; however, it failed to sound. R3 stated he stretched and slid to his butt. The FSI's teams meeting note, undated, remained blank; however, team member signatures were present. -On 4/25/23, R3 informed staff he fell in his room that afternoon around 1:00 p.m. He stated he lost his balance when he attempted to get his dirty laundry together. He wore his usual sandals. The	F 689		

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F 689	Continued From page 7 alarm sensor was in the w/c; however, when staff tested it, it failed to function properly, and the low battery light flashed. Battery and sensor pad were changed and functioned after. The note indicated R3 was a fall risk and required SBA of one staff for transfers and frequently self-transferred. The FSI report indicated R3 wore sandals and time last toileted was unknown as R3 toileted himself. Root cause of the fall was identified as R3 should be SBA, the alarm had a low battery, and R3 preferred sandals. The teams meeting note, undated, indicated an occupational therapist (OT) walked by R3's room around that time and he was seated in his w/c, the bed alarm sounded, and R3 talked about his laundry. -On 4/26/23 at 7:30 a.m., R3 was witnessed to slide out of his w/c. He stated he attempted to get an eye drop that fell under the bed. The FSI indicated R3 wore slippers at that time and the team meeting note, undated, remained blank: however, team member signatures were present. -On 4/26/23, R3 attended a care conference. His daughter joined by phone. The note identified R3 requested to have the toilet riser removed from this toilet. The note lacked additional related information. R3 required SBA for transfers but R3 failed to call staff or wait for assist which resulted in frequent falls. Bed and chair alarms were in place; however, he turned them off despite reminders to use his call light and wait for assist. R3 tended to decline activity invites. And thus, activity staff provided R3 with one-to-one visits. The note lacked information related to any additional fall intervention discussion. -On 4/26/23, R3 self-transferred multiple times that shift. His alarm functioned; however, he usually self-transferred before staff could respond. Reminders to use call light and to make sure his brakes were on were provided.	F 689		

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F 689	Continued From page 8 -On 4/28/23, R3 was assessed to toilet without the commode over the toilet and did well. Signs were placed next to the toilet and by his bed to remind him to lock his w/c breaks. "He does have the anti-rollback brakes, but they will loosen over time and need to be tightened, so signs were placed as a precaution." -On 4/30/23 at 10:20 a.m., R3 was seated on the floor with his feet in the w/c. Prior to this, he was observed to fall asleep across his bed with his feet in the w/c. This was "quite common for him." The FSI report identified a team meeting note, undated, which indicated a work order was submitted to adjust the anti-rollback brakes. -On 5/10/23, R3 was found on the toilet after alarm sounded. -On 5/11/23, R3 was found getting out of bed after alarm sounded in which he stated he needed to use the bathroom. -On 5/17/23, R3 updated staff he 'just blacked out." Blood pressure at that time was 95/70 and heart rate was 99. He was encouraged to drink more water and avoid coffee. Follow-up vitals two hours later identified his blood pressure and heart rate were WNL and no further concerns were identified. -On 5/17/23 at 8:00 p.m., R3 was seated on the television room floor in front of his w/c. He stated he reached for something which took the best of him, and he tipped over. The FSI's team meeting note, undated, remained blank: however, team member signatures were present. -On 5/22/23, at 7:40 p.m., R3 was on his knee in front of his recliner. The FSI report identified R3 attempted to sit in the recliner and the team meeting note, undated, remained blank: however, team member signatures were present. -On 5/28/23, R3 was seated in his w/c at the lunch table without the alarm pad under him. He	F 689		

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F 689	Continued From page 9 disassembled it and removed it. Staff assembled the alarm and replaced in the chair. -On 5/30/23 at 7:00 p.m., R3 was on his right side on the hallway floor near the memory care unit. The alarm sounded. He stated he thought he could walk but he went down. The FSI identified physical therapy (PT) walked with him that afternoon and thus he thought he could walk. The teams meeting note, undated, remained blank; however, team member signatures were present. -On 6/3/23, R3 set off the bed or chair alarms "over 15 times this shift ..." -On 6/5/23, R3 sat on a "roller chair" behind the desk and he was redirected back to his own w/c. -On 6/18/23, R3 self-transferred to parked wheelchairs in the hallway in which he was very hard to redirect. -On 6/23/23, R3 was found in the therapy room where he attempted to climb onto one of the therapy beds. -On 6/29/23, R3 attempted to self-transfer in the common area. -On 7/1/23 at 9:30 a.m., R3 was seated on the floor with crossed legs next to his w/c. He stated he went to pick a battery up from the floor and fell when he slide out of his chair. The FSI's team meeting note, undated, identified R3 utilized a sensor pad alarm and anti-roll back brakes on w/c already as fall prevention interventions. R3's Fall Risk Assessment, dated 7/7/23, identified a score of 24 (high risk) related to multiple falls over the last six months, medication usage, occasional bladder incontinence, orthostatic hypotension, poorly fitted shoes, exhibited short discontinuous steps and/or shuffled steps and required hands-on assistance to move from place to place with an assistive device. The assessment lacked a comprehensive	F 689		

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F 689	Continued From page 10 fall risk analysis based on the identified information. R3's care plan lacked revision(s) based on the fall risk assessment and R3's increased fall risk score. R3's subsequent progress notes and facility provided FSI reports identified the following information: -On 7/12/23 at 7:00 p.m., R3 was seated on the floor parallel to his bed. The alarm sounded. An FSI was not provided. -On 7/13/23, an MDS note identified R3 was gradually became more confused and was severely cognitively impaired. His transfer ability varied day to day from SBA to hands on and needed assist of one staff for ambulation due to unsteadiness. R3 was manipulative and demonstrated impaired safety awareness with attempted self-transfers and ambulation in his room. A significant change MDS was initiated. -On 7/13/23 at 6:30 p.m., R3 was on the floor on his back and side. He confirmed he hit his head and was unable to explain the reason for the fall. His speech was "noticeable more slurred." Neuros assessed in which left eye reacted WNL for him; however, the right eye which at baseline was a 3mm and sluggish to light was assessed at a 2 and non-reactive to light. The on-call provider was updated and R3 was brought to the emergency department for observation. The FSI indicated the fall occurred by the television lounge; however, the report lacked information related to post fall huddle information, root cause of the fall, or the completing nurse information. In addition, the team meeting notes also remained blank with no team member signatures. -An ED provider progress note, dated 7/13/23, indicated facility staff reported R3's speech seemed more garbled, he was more confused,	F 689		

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F 689	Continued From page 11 and he was more incontinent that day which was "unlike [R3]." The note indicated R3's pupils were not equal; however, it appeared as if R3 had cataract surgery on the left eye and there were no acute findings identified on the head and cervical spine CT scans. Plan was for R3 to follow-up on an outpatient basis for a repeat CT scan as R3 took aspirin and Plavix. Discharge orders identified diagnoses of unspecified head injury, fall on same level, and repeated falls. -On 7/13/23 at 10:43 p.m., R3 returned to the facility. Neuros were performed and R3's right pupil reacted per prior baseline. -On 7/16/23 at 3:10 a.m., R3 was seated on the bathroom floor. The alarm sounded. The w/c was next to the toilet and the breaks were locked and his pants were wet "apparently from urine incontinence." R3 stated he fell against the wall and then to the floor. He confirmed he hit his head and that his hand was hurt in the fall. The note identified an intervention: "Recommendation for a toileting schedule." The FSI identified R3 remained in bed for about six hours prior to the fall and indicated due to R3's instability and impulsivity when he needed to void the nurse recommended a toileting plan on night shift. The team meeting note, dated 7/17/23, indicated R3's care plan identified, "Toilet Q (every) 2 hrs (hours) and PRN (as needed)" and this was added to the POC (plan of care) task list. In addition, a PT evaluation/screen was requested. Nursing assistant (NA) care/group sheets indicated R3 required SBA with ambulation and transfers, Q two hour and PRN toileting, and a motion sensor pad on bed, w/c, and recliner, along with a wanderguard (device that alarms when leaves facility) on his w/c. The sheet lacked information related to R3's fall risk factors	F 689		

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F 689	Continued From page 12 and/or any other fall mitigation interventions. R3's medical provider dictated progress notes identified the following information: -1/19/23: R3 required a lot of redirection and he did not like a lot of assistance. He self-transferred in which bed and chair alarms were used to "keep him safer." -3/16/23: R3 was "extremely impulsive" and "will get up and move when he is recommended not to" in which alarm on bed and w/c utilized. During the visit, the provided observed R3's transfer multiple times in his room in which R3 moved "quite well today." After the visit, R3 wheeled throughout the nursing home; "intermittently getting up and setting off his alarms." Plan to continue current therapies and follow-up in one month. -4/20/23: R3 was assisted with all ADLs, but self-transfers. R3 had not left the building again after last month's episode where he ran and fell in the parking lot. Assessment and plan were for continued behavioral monitoring to assist in potential behavioral medication adjustments. -5/25/23: No identification of fall history since last visit. Assessment and plan were to continue him with behavioral medications in setting of his dementia with impulsivity and labile emotional status which has "been very helpful in managing ..." -6/8/23: R3 complained he felt like the vision out of his right eye was not very good. It appeared to him to be 'wobbly or wavy' which had gotten steadily worse over the last few weeks. An ophthalmologic evaluation was indicated as "this could be a retinal injury." -7/7/23: R3 was started on an antidepressant medication to improve his appetite and decrease some of his abusive language toward staff. Pain	F 689		

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	245127	A. BUILDING _____ B. WING _____	C 07/17/2023

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F 689	Continued From page 13 medications were also adjusted due to complaints of back pain. R3's medical provider notes lacked documentation R3's provider was involved in a comprehensive fall risk assessment/analysis process related to R3's numerous falls. R3's medical record identified R3's fall risk was assessed on 1/5/23, 4/11/23, and 7/7/23 based on the MDS process; however, the record lacked comprehensive fall risk assessment analysis' were completed after R3's multiple falls to develop, adjust, and/or monitor for effectiveness of individualized care plan interventions, to mitigate R3's fall and/or fall injury risk, which were based on his high fall risk factors identified in the fall risk assessments and in the progress notes. During interview on 7/14/23 at 11:59 a.m., licensed practical nurse (LPN)-A stated when a resident fell the resident was to be assessed, a fall huddle conducted to review the fall and determine if there was anything that could have been done differently, and to implement any new interventions if applicable to prevent further falls; however, she explained "usually after a couple falls" interventions would be implemented "within a week" and if the resident fell "too many times" or if there was an imminent need the provider would be called right away to "get an order for something." She stated any fall intervention was expected to be place on the care plan. LPN-A stated R3 was "a major fall risk" due to continued unsteady self-transfers with "too many falls," significant impulsivity, and fluctuations in his cognitive status where he lacked cognition to understand his fall risk. She identified R3's fall interventions were as follows: alarms, anti-roll	F 689		

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F 689	Continued From page 14 back breaks, pain management, keep him busy, alarm checks each shift to ensure function, and attempts to keep him closer to her with extra rounds to check on him which she completed per her own choice. She explained R3 enjoyed staying busy, liked social interaction, and occasionally placed his feet on his w/c when he laid across the bed. She denied R3 utilized a toileting plan and was unsure as to why; however, she explained "he has always been pretty good about asking [to go to the bathroom]." She denied any recent changes to R3's fall interventions and was unsure of any interventions she would implement that potentially would decrease R3's fall risk. During observation on 7/14/23 at 2:09 p.m., R3 laid in bed appropriately with his eyes open. His room was situated directly across from one side of the nurse's station. When approached he quickly uncovered himself and sat up at the edge of the bed. Staff seated at nurses' station were alerted by surveyor as he appeared as if he was going to self-transfer to the w/c situated right next to the edge of his bed. The w/c breaks were engaged, and he utilized gripper socks. As he stood up and staff situated themselves next to him the bed alarm engaged. He demonstrated an unsteady transfer to the w/c in which staff provided contact guard (hands on) assist. A standard call-light was located at the head of the bed, anti-roll breaks were in place on the w/c, a standard mattress was in place and the bed was positioned at a standard height, a commode frame was over his toilet, and signs on the wall next to the bed and in the bathroom on the wall across from the toilet encouraged him to lock his breaks. The signs did not direct him to wait and call for help. Once in w/c, staff placed shoes with	F 689		

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F 689	Continued From page 15 Velcro closures on him. R3 was free of pain indicators; however, he displayed cognitive impairments and asked surveyor if she was going to go babysitting. When interviewed on 7/14/23 at 2:14 p.m., NA-C stated she utilized the NA group sheets, kept at the nurse's station, for resident need(s) information and fall risk interventions; however, she "just kind of knows" what the resident needs are and what the fall interventions were. She explained she was expected to follow the plan of care/NA group sheets and the managers were very good at emailing updates to staff. She considered R3 to be a fall risk as he was constantly up and down in which he was very busy and was known to take off the alarms and/or unplug them. He preferred staff not watch him, or help him, while he toileted and his cognitive status fluctuated. If staff heard the alarms, they knew he was in the bathroom, and they would then stand close and provide any assist he allowed or he "pretty much" informed them when he needed the bathroom. She denied R3 utilized a toileting plan; however, at the end of the interview when she was asked to show where the group sheets were kept, she reviewed R3's group sheet information and confirmed he had a toileting plan in place. NA-C stated she attempted to keep R3 closer to the nurse's station, attempted to keep his door open when he was in there, and always looked in his room when she walked by to help mitigate falls. She explained the only intervention that would stop his falls would be 1:1 supervision and was unsure of any other interventions to help mitigate R3's falls and/or fall risk. She denied management staff involved her in any fall analysis and/or intervention conversations.	F 689		

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F 689	Continued From page 16 During interview on 7/14/23 at 2:39 p.m., LPN-B stated staff were not provided a lot of specific details about the residents; however, they were expected to follow the NA group sheet in which staff are supposed to review the sheets before starting their shift. LPN-B considered R3 to be a fall risk in which it was hard to know when R3 was going to fall. LPN-B stated R3 utilized alarms; however, the alarms agitated R3 when he "moved back and forth." Despite this, the alarms were required to help alert staff when he transferred, or moved around, so they could assist as soon as possible with whatever R3 needed. LPN-B explained communication amongst the nurses had occurred related to the alarm agitation; however, he denied he relayed this information to management. LPN-B denied management asked for his input into R3's falls or thoughts on fall interventions. He explained keeping R3 from falling could not be avoided as "things just happen" but he stated a comprehensive group discussion would be required to come up with interventions and build a solid frame to address R3's fall risk and his status fluctuations. When interviewed on 7/14/23 at 3:10 p.m., NA-D stated she was expected to follow the NA group sheet for fall interventions and care needs. She explained R3 was a fall risk and already that shift he had been "up and down from bed five to six times" as R3 was a "very confused busy guy." She explained she attempted to keep him busy, such as rummaging through his drawers or listening to music which he seemed to enjoy, while also trying to keep him located nearby with more 1:1 supervision. R3 required toileting every two hours and was not very good at alerting staff	F 689		

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F 689	Continued From page 17 of his needs. In addition, he liked to lay in bed with his legs up on the w/c seat. Anti-roll breaks were utilized, along with alarms which did not appear to bother him. NA-D identified R3's fall risk may be decreased if he was involved in more 1:1 activity, assisted to listen to his preferred music, or engaged in conversation about his native American heritage as he liked when staff provided him with "attention." She confirmed she did not communicate these suggestions with activity or any other staff and denied management staff involved her in any fall analysis and/or intervention conversations. During interview on 7/14/23 at 3:25 p.m. activity aide (AA)-A stated she was not aware of details surrounding any of R3's falls or the extent of how often R3 fell. She stated R3 was not provided 1:1 sessions with activity staff and overall, they just invited him to activities; however, he was not one to typically stick around. If they had spare time and encountered him in the hallway or in his room, they would interact with him. She denied staff had approached her to update her about potential activity involvement to decrease his fall risk nor involved her in any fall analysis and/or intervention conversations. On 7/17/23 at 10:50 a.m., during a telephone interview, R3's family member (FM)-A stated she was invited to two care conference to talk about R3. She was able to attend one and another family member attended the other. No additional conferences have occurred. She denied being involved in any discussion related to R3's falls or to get her intake on possible interventions. She was aware R3 frequently fell, and she indicated R3 required alarms to alert staff when he	F 689		

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F 689	Continued From page 18 self-transferred. She believed R3's falls were related to his dementia process. She explained staff adjusted his medications related to his behaviors and performed lab work, but otherwise she was unsure what interventions were in place to mitigate falls. She stated she expected R3 would be on a toileting plan as he had a history of frequency and she further expected staff kept him busy and distracted as he always liked to play with, fiddle with, or straighten things up in his garage. He enjoyed smoking and talking on the phone, he also found comfort with animals, and always kept himself busy. FM-A stated R3 had a longer standing history of vertigo which may also be a factor which increased his fall risk. She stated she had a phone call from staff on 7/14/23 and she expressed her concern related to that; however, she was unsure what the staff did with that information. On 7/17/23 at 10:56 a.m. the clinic for R3's medical provider was called. Receptionist staff stated the provider was out of clinic until 7/19/23; however, a message would be relayed to him that day to return a call. At the time of the exit conference, the provider had yet to response to the message and thus was not interviewed. When interviewed on 7/17/23 at 12:04 p.m. activity aide (AA)-B stated she was currently the acting interim activity director. She stated she was not aware of the extent of R3's falls or details surrounding his falls as she did not attend the morning's interdisciplinary team (IDT) meetings. She identified currently no one was represented from activities in this meeting. She denied anyone from nursing approached her to involve her in any fall analysis and/or intervention conversations; however, after she talked with AA-A following her	F 689		

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F 689	Continued From page 19 interview on 7/14/23, they talked about setting R3 up to participate in a smaller men's sensory group that met once a week and some other potential interventions as R3 was a very busy man in which he liked to stand up and go through his pockets. During interview on 7/17/23 at 12:33 p.m. the DON stated fall assessments were completed with the MDS process i.e., on admission, quarterly, annually, significant change in status and denied they were completed at any other times. Once completed, the care plan was to be updated with information based on the assessment. If a resident fell, she expected staff to follow the fall protocols which included a fall huddle and fall intervention(s) implementation. The IDT then meet three times a week and discussed the falls that occurred, reviewed the incident reports, ensured they were completed as expected, and revised and/or implemented additional fall interventions. She explained this process would be documented either in the progress notes and/or on the incident report (FSI). If documentation was not found in either of these two areas, she would assume this expectation was not followed. The DON explained intervention revision and/or initiation was important to prevent continued falls, injury, or death. She stated R3 had numerous falls in which he initially had anti-roll breaks on his wheelchair, along with alarms in bed and w/c. Initially, R3 would unhook these and remove them from the bed or w/c; however, he currently left them alone. In addition, initially the anti-roll brakes malfunctioned, and he was provided a new w/c and brakes; however, they were not a success as he continued to have more falls. R3 initially worked with PT but his dementia and follow through was not good. Signs were placed in his	F 689		

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F 689	Continued From page 20 room but "the signs do not work," "It is just another intervention," that she was hopeful worked for him. With R3's fall on 7/16/23, staff recommended a toileting plan; however, because this was already inplace, she added, this morning, a section in POC (plan of care NA documentation section in electronic medical record) where staff were required to document toileting every two hours. A PT referral was also requested as R3 seemed weaker. In addition, R3's room was by the nurse's station and discussions were had with his primary provider about his behavioral medications and adjustments were made. She acknowledged R3 experienced periods of dizziness with orthostatic hypotension but was unsure if R3's provider was aware of this risk. She explained R3 no longer utilized the sandals and currently used shoes with Velcro closures which he did not like tight. She stated they seemed to fit him well but was unsure if they were ever assessed for proper fit. The DON was unsure if R3's falls were ever comprehensively analyzed. She stated a quality safety committee met and discussed falls. She was unable to remember exact details related to last week's meeting but felt R3's falls were discussed. She was unable to provide meeting minutes as she explained no one took notes during the meeting. When interviewed on 7/17/23 at 4:10 p.m. the administrator stated he was part of the organizations fall committee which met once a month. During this meeting staff talked about all the falls that occurred and overall completed root cause analysis on each one. They also looked for trends and areas of opportunity to improve. He identified R3 was discussed at these meetings; however, was unable to provide specific details related to R3.	F 689		

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F 689	Continued From page 21 Fall Committee meeting minutes were requested; however, none were provided. A Falls and Fall Prevention policy, undated, indicated the facility's goal was to prevent and reduce as many falls as possible while the resident's independence was optimized, and they were provided individualized resident centered care. The policies Procedure - Fall Prevention section directed nursing to complete an initial assessment of the resident and identify risk for falls and to implement a care plan based on the resident's assessment, history of falls, use of physical assistance equipment, and physician orders. In addition, the policy directed a post fall follow-up to be conducted to learn the circumstances surrounding the fall and for the nurse to complete the nurse's portion of the FSI. The policy lacked direction related to additional fall risk assessments and subsequent analysis', expectations for fall intervention initiation after a fall, and/or processes if a resident experienced multiple falls. The FSI lacked an area within the nurse portion of the report to document intervention information after the fall. The Fall Huddle section asked for information related to "What was different THIS time." The report only indicated an area for steps/actions planned within the Falls Team Meeting Notes which was completed during the IDT review process. A Care Plan Procedure, undated, identified its purpose was to provide each resident with an individualized care plan that was developed following the initial and comprehensive assessment which assisted the resident to attain	F 689		

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F 689	Continued From page 22 or maintain their highest practicable physical, mental, and psychosocial well-being. The procedure directed the plan of care would be periodically updated to provide for increased quality and continuity of care between all care disciplines and staff. In addition, all staff were expected to follow the plan of care unless the resident exercised their right to refuse or had significant changes that prohibited the completion of the care plan. The care plan was expected to include interventions specific enough to guide the provision of care and be updated based on assessments, changes in condition, physician orders or other IDT recommendations. A Resident Assessment policy, undated, identified it was designed to assure current, comprehensive assessment of each resident's needs. A section labeled Falls Assessment directed this to be completed within the first assessment reference date (ARD) of the MDS process, after admission, quarterly, annually, and with a significant change in status. [All based on MDS process]. A section labeled Interdisciplinary Care Plan identified it was to be updated with changes that occurred between reviews [MDS processes].	F 689		

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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 7/14/23 and 7/17/23, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed with no deficiency issued: H51273573C (MN00095183). However; as a result of the investigation, a licensing order was issued at 0830. 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	2 000		

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2 000	Continued From page 2 state form. 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.	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 comprehensively assess fall risk and implement individualized interventions to reduce the risk of falls for 1 of 3 residents (R3) reviewed for accidents. This resulted in R3 falling 18 times since his January 2023 admission. Findings include: R3's admission Minimum Data Set (MDS), dated 1/12/23, identified R3 admitted to the facility on	2 830	Corrected	8/24/23

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	00374	A. BUILDING: _____ B. WING _____	07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 3 1/5/23. He was moderately cognitively impaired and received limited physical assist with ambulation, transfers, and toileting. He was frequently incontinence of bladder. Diagnoses included dementia with behavioral disturbances, benign prostatic hypertrophy (BPH - enlarged prostate), and macular degeneration (eye condition impacting central vision). In addition, the MDS identified R3 fell prior to admission and utilized bed and chair alarms daily. R3's quarterly MDS, dated 4/13/23, identified R3 was severely cognitively impaired and received supervision with ambulation, transfers, and toileting. He was occasionally incontinent of bladder. Diagnosis included dementia with behavioral disturbances. In addition, the MDS identified R3 fell two or more times with no injury and two or more times with non-major injury and utilized bed and chair alarms daily. R3's Fall Risk Assessment, dated 1/5/23, identified a score of 14 (moderate risk). The assessment indicated R3 was free of falls prior to admission; however, at risk due to medication usage, occasional bladder incontinence, poorly fitted shoes, exhibited short discontinuous steps and/or shuffled steps and instability during turns, and the required need for assistive device to walk. R3 was free of systolic blood pressure drops of 20mmHG or more between lying and standing (orthostatic hypotension). The assessment lacked a comprehensive fall risk analysis based on the identified information. R3's admission MDS driven Fall Care Area Assessment (CAA), dated 1/17/23, identified R3 fell on 12/20/22 while at the hospital. He was unsteady on his feet and declined to use the PT recommended walker and thus utilized a	2 830		

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2 830	Continued From page 4 wheelchair (w/c) for locomotion and to transfer. Upon admission, therapy recommended he required stand by assist (SBA) for mobility. R3 was diagnosed with dementia with behaviors and currently utilized antipsychotic medications. Additional diagnoses included cardiac condition, anemia, and BPH. He maintained bowel control; however, was incontinent of bladder and was found to have an enlarged prostate and started on medication while in the hospital. He was offered toileting every two hours and upon his request. Hearing loss was present, and he did not wear hearing aids. Pain management was in place due to history of headaches and back pain. Due to edema (swelling) he wore a slip-on shoe. Adequate vision was assessed; however, vision loss reported in right eye. R3 required a motion sensor pad on bed, w/c, and recliner and he was free of significant drops in orthostatic blood pressure. The fall risk assessment indicated a moderate fall risk. The CAA indicated staff would proceed to care plan for interventions to minimize risk factors. The CAA lacked evidence staff completed a comprehensive fall assessment analysis or individualized intervention(s) identification based on R3's fall risk. R3's care plan identified the following information: -On 1/19/23, a Vulnerable Adult Focus was initiated with a goal he would remain safe while he lived at the facility. -On 1/23/23, a Potential for Falls Focus was initiated related to "altered mobility, vision, medication, edema, past history of falls, incontinence" with a revised goal on 2/6/23 to remain free of fall related injury. The following interventions were implemented: medication monitoring for adverse reactions and continued need, encouragement of feet elevation and appropriate footwear use, follow mobility, vision,	2 830		

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2 830	Continued From page 5 and toileting care plans, keep frequently used items within reach and room free of clutter, motion sensor pad on bed, w/c, and in recliner. -On 1/23/23, an Alteration in Toileting/Elimination Focus was initiated and directed staff to offer R3 the toilet every two hours and upon request. -On 1/24/23, an Alteration in Mobility Focus was initiated related to weakness and dementia and identified R3 required 1 staff for ambulation and transfers. -On 4/26/23, the Potential for Falls Focus was revised to include anti-rollback brakes on w/c. -On 7/14/23, the Alteration in Cognition Focus, was revised and identified R3 had dementia with behaviors and displayed impaired safety awareness and decision making, along with short- and long-term memory changes. R3's subsequent progress notes and facility provided Fall Scene Investigation Reports (FSI) identified the following information: -On 1/8/23, R3 self-transferred repeatedly and required reminders to use the call light, frequent safety checks, redirection, and assist with toileting needs. -On 1/9/23, R3 removed the alarm sensor pad out of his w/c on two separate occasions, self-transferred and required one-on-one supervision. -On 1/13/23, R3 self-transferred to the toilet and stated he had to go, or he was going to have an accident. -On 1/18/23, R3 attended a care conference with his family. Due to his self-transfers, bed and chair alarms were used. The note lacked information related to any additional fall intervention discussion. -On 1/19/23, R3 lost his balance and slowly lowered himself to the floor next to his bed. A FSI was not provided.	2 830		

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2 830	Continued From page 6 -On 1/21/23 and 1/22/32, R3 "constantly" self-transferred/toileted. -On 1/24/23 at 7:20 p.m., R3 was seated on his buttocks in front of the bed. The alarm failed to sound. He stated he forgot to lock his w/c breaks. His conversation was confused but at baseline. Neurological (neuro) assessment was within normal limits (WNL). The FSI indicated the alarm failed as R3 turned it off. The Falls Team Meeting Notes embedded within the FSI identified the fall was reviewed on 1/25/23 in which a maintenance request was submitted for anti-rollback brakes on 1/24/23, prior to the fall, which had yet to be completed. -On 1/25/23, R3 complained of upper neck and bilateral shoulder pain which he stated, "happened awhile back when he fell in the bathroom." -On 1/26/23, R3 removed his alarms and turned them off on numerous occasions. Staff intercepted R3 when he self-transferred. He "nearly missed" the w/c and landed on the arm rest. A FSI was not provided. -On 2/2/23, R3 was seated on the bathroom floor next to the toilet. He sustained a "moderate" sized abrasion to his right hip and complained of right sided temple tenderness. Neuro assessment was WNL. -On 2/3/23, neuros were performed on R3 in which his right pupil was a 2 in size and had no reaction to light and his left pupil was a 3 in size and reacted briskly to light. R3 received a right eye injection that morning during an appointment. A FSI report was not provided. -On 2/5/23, R3 was found lying on his bedroom floor. The alarm sounded. He stated he was reaching under the bed for his remote. He denied falling. A FSI was not provided. -On 2/11/23 at 6:55 a.m., R3 was seated on the floor with his head on the bed. The alarm	2 830		

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2 830	Continued From page 7 sounded. He stated he was unsure where he was or what he tried to do. His w/c was pointed to the door and unlocked. "Pupils were 2mm (millimeters) sluggish." A follow-up note on 2/11/23, indicated right pupil was 2mm sluggish and left pupil was 3mm reactive. A FSI report identified R3 wore "flip flops," the w/c was unlocked, and he stated his "eyes were not working." In addition, the rear w/c wheel anti-lock brake failed to work. The team meeting note, dated by the director of nursing (DON) on 3/29/23, identified the w/c was repaired. -On 2/13/23, R3 walked in his room without walker or chair. The alarm sounded. When staff "grabbed" at his pants to help him, he attempted to hit staff and "almost fell." -On 3/26/23 at 11:30 p.m., R3 eloped from the facility and ran down a sidewalk away from staff who chased him. He stepped off a sidewalk curb. The momentum lunged him forward onto the pavement. R3 exhibited hallucinations when staff reached him. He sustained abrasions to his right 5th finger, right knee, right elbow, left calf, left palm, and required added support for transfers for the hours that proceeded the fall. The FSI's team meeting notes, undated, indicated a medication (unidentified) was increased. -On 4/6/23 at 6:30 p.m., R3 was seated on his bedroom floor. Socks and sandals were on. He stated he hit his head and neuros were at his baseline. The alarm sensor pad sat on his bedside table. Staff replaced the sensor pad back in w/c. The FSI indicated R3 was "slightly more confused than baseline." The teams meeting note, undated, remained blank; however, team member signatures were present. R3's Fall Risk Assessment, dated 4/11/23, identified a score of 23 (high risk) related to multiple falls over the last six months, medication	2 830		

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2 830	Continued From page 8 usage, occasional bladder incontinence, experienced orthostatic hypotension, poorly fitted shoes, exhibited short discontinuous steps and/or shuffled steps instability during turns, and the required need for assistive device to walk. The assessment lacked a comprehensive fall risk analysis based on the identified information. R3's care plan lacked revision(s) based on the fall risk assessment and R3's increased fall risk score. R3's subsequent progress notes and facility provided FSI reports identified the following information: -On 4/24/23 at 8:30 p.m., R3 was seated on the television room floor in front of his w/c. Alarm functioned; however, it failed to sound. R3 stated he stretched and slid to his butt. The FSI's teams meeting note, undated, remained blank; however, team member signatures were present. -On 4/25/23, R3 informed staff he fell in his room that afternoon around 1:00 p.m. He stated he lost his balance when he attempted to get his dirty laundry together. He wore his usual sandals. The alarm sensor was in the w/c; however, when staff tested it, it failed to function properly, and the low battery light flashed. Battery and sensor pad were changed and functioned after. The note indicated R3 was a fall risk and required SBA of one staff for transfers and frequently self-transferred. The FSI report indicated R3 wore sandals and time last toileted was unknown as R3 toileted himself. Root cause of the fall was identified as R3 should be SBA, the alarm had a low battery, and R3 preferred sandals. The teams meeting note, undated, indicated an occupational therapist (OT) walked by R3's room around that time and he was seated in his w/c, the bed alarm sounded, and R3 talked about his laundry. -On 4/26/23 at 7:30 a.m., R3 was witnessed to slide out of his w/c. He stated he attempted to get	2 830		

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2 830	Continued From page 9 an eye drop that fell under the bed. The FSI indicated R3 wore slippers at that time and the team meeting note, undated, remained blank: however, team member signatures were present. -On 4/26/23, R3 attended a care conference. His daughter joined by phone. The note identified R3 requested to have the toilet riser removed from this toilet. The note lacked additional related information. R3 required SBA for transfers but R3 failed to call staff or wait for assist which resulted in frequent falls. Bed and chair alarms were in place; however, he turned them off despite reminders to use his call light and wait for assist. R3 tended to decline activity invites. And thus, activity staff provided R3 with one-to-one visits. The note lacked information related to any additional fall intervention discussion. -On 4/26/23, R3 self-transferred multiple times that shift. His alarm functioned; however, he usually self-transferred before staff could respond. Reminders to use call light and to make sure his brakes were on were provided. -On 4/28/23, R3 was assessed to toilet without the commode over the toilet and did well. Signs were placed next to the toilet and by his bed to remind him to lock his w/c breaks. "He does have the anti-rollback brakes, but they will loosen over time and need to be tightened, so signs were placed as a precaution." -On 4/30/23 at 10:20 a.m., R3 was seated on the floor with his feet in the w/c. Prior to this, he was observed to fall asleep across his bed with his feet in the w/c. This was "quite common for him." The FSI report identified a team meeting note, undated, which indicated a work order was submitted to adjust the anti-rollback brakes. -On 5/10/23, R3 was found on the toilet after alarm sounded. -On 5/11/23, R3 was found getting out of bed after alarm sounded in which he stated he	2 830		

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2 830	Continued From page 10 needed to use the bathroom. -On 5/17/23, R3 updated staff he 'just blacked out." Blood pressure at that time was 95/70 and heart rate was 99. He was encouraged to drink more water and avoid coffee. Follow-up vitals two hours later identified his blood pressure and heart rate were WNL and no further concerns were identified. -On 5/17/23 at 8:00 p.m., R3 was seated on the television room floor in front of his w/c. He stated he reached for something which took the best of him, and he tipped over. The FSI's team meeting note, undated, remained blank: however, team member signatures were present. -On 5/22/23, at 7:40 p.m., R3 was on his knee in front of his recliner. The FSI report identified R3 attempted to sit in the recliner and the team meeting note, undated, remained blank: however, team member signatures were present. -On 5/28/23, R3 was seated in his w/c at the lunch table without the alarm pad under him. He disassembled it and removed it. Staff assembled the alarm and replaced in the chair. -On 5/30/23 at 7:00 p.m., R3 was on his right side on the hallway floor near the memory care unit. The alarm sounded. He stated he thought he could walk but he went down. The FSI identified physical therapy (PT) walked with him that afternoon and thus he thought he could walk. The teams meeting note, undated, remained blank; however, team member signatures were present. -On 6/3/23, R3 set off the bed or chair alarms "over 15 times this shift ..." -On 6/5/23, R3 sat on a "roller chair" behind the desk and he was redirected back to his own w/c. -On 6/18/23, R3 self-transferred to parked wheelchairs in the hallway in which he was very hard to redirect. -On 6/23/23, R3 was found in the therapy room where he attempted to climb onto one of the	2 830		

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2 830	Continued From page 11 therapy beds. -On 6/29/23, R3 attempted to self-transfer in the common area. -On 7/1/23 at 9:30 a.m., R3 was seated on the floor with crossed legs next to his w/c. He stated he went to pick a battery up from the floor and fell when he slide out of his chair. The FSI's team meeting note, undated, identified R3 utilized a sensor pad alarm and anti-roll back brakes on w/c already as fall prevention interventions. R3's Fall Risk Assessment, dated 7/7/23, identified a score of 24 (high risk) related to multiple falls over the last six months, medication usage, occasional bladder incontinence, orthostatic hypotension, poorly fitted shoes, exhibited short discontinuous steps and/or shuffled steps and required hands-on assistance to move from place to place with an assistive device. The assessment lacked a comprehensive fall risk analysis based on the identified information. R3's care plan lacked revision(s) based on the fall risk assessment and R3's increased fall risk score. R3's subsequent progress notes and facility provided FSI reports identified the following information: -On 7/12/23 at 7:00 p.m., R3 was seated on the floor parallel to his bed. The alarm sounded. An FSI was not provided. -On 7/13/23, an MDS note identified R3 was gradually became more confused and was severely cognitively impaired. His transfer ability varied day to day from SBA to hands on and needed assist of one staff for ambulation due to unsteadiness. R3 was manipulative and demonstrated impaired safety awareness with attempted self-transfers and ambulation in his room. A significant change MDS was initiated.	2 830		

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2 830	Continued From page 12 -On 7/13/23 at 6:30 p.m., R3 was on the floor on his back and side. He confirmed he hit his head and was unable to explain the reason for the fall. His speech was "noticeable more slurred." Neuros assessed in which left eye reacted WNL for him; however, the right eye which at baseline was a 3mm and sluggish to light was assessed at a 2 and non-reactive to light. The on-call provider was updated and R3 was brought to the emergency department for observation. The FSI indicated the fall occurred by the television lounge; however, the report lacked information related to post fall huddle information, root cause of the fall, or the completing nurse information. In addition, the team meeting notes also remained blank with no team member signatures. -An ED provider progress note, dated 7/13/23, indicated facility staff reported R3's speech seemed more garbled, he was more confused, and he was more incontinent that day which was "unlike [R3]." The note indicated R3's pupils were not equal; however, it appeared as if R3 had cataract surgery on the left eye and there were no acute findings identified on the head and cervical spine CT scans. Plan was for R3 to follow-up on an outpatient basis for a repeat CT scan as R3 took aspirin and Plavix. Discharge orders identified diagnoses of unspecified head injury, fall on same level, and repeated falls. -On 7/13/23 at 10:43 p.m., R3 returned to the facility. Neuros were performed and R3's right pupil reacted per prior baseline. -On 7/16/23 at 3:10 a.m., R3 was seated on the bathroom floor. The alarm sounded. The w/c was next to the toilet and the breaks were locked and his pants were wet "apparently from urine incontinence." R3 stated he fell against the wall and then to the floor. He confirmed he hit his head and that his hand was hurt in the fall. The note identified an intervention: "Recommendation	2 830		

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2 830	Continued From page 13 for a toileting schedule." The FSI identified R3 remained in bed for about six hours prior to the fall and indicated due to R3's instability and impulsivity when he needed to void the nurse recommended a toileting plan on night shift. The team meeting note, dated 7/17/23, indicated R3's care plan identified, "Toilet Q (every) 2 hrs (hours) and PRN (as needed)" and this was added to the POC (plan of care) task list. In addition, a PT evaluation/screen was requested. Nursing assistant (NA) care/group sheets indicated R3 required SBA with ambulation and transfers, Q two hour and PRN toileting, and a motion sensor pad on bed, w/c, and recliner, along with a wanderguard (device that alarms when leaves facility) on his w/c. The sheet lacked information related to R3's fall risk factors and/or any other fall mitigation interventions. R3's medical provider dictated progress notes identified the following information: -1/19/23: R3 required a lot of redirection and he did not like a lot of assistance. He self-transferred in which bed and chair alarms were used to "keep him safer." -3/16/23: R3 was "extremely impulsive" and "will get up and move when he is recommended not to" in which alarm on bed and w/c utilized. During the visit, the provided observed R3's transfer multiple times in his room in which R3 moved "quite well today." After the visit, R3 wheeled throughout the nursing home; "intermittently getting up and setting off his alarms." Plan to continue current therapies and follow-up in one month. -4/20/23: R3 was assisted with all ADLs, but self-transfers. R3 had not left the building again after last month's episode where he ran and fell in the parking lot. Assessment and plan were for	2 830		

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2 830	Continued From page 14 continued behavioral monitoring to assist in potential behavioral medication adjustments. -5/25/23: No identification of fall history since last visit. Assessment and plan were to continue him with behavioral medications in setting of his dementia with impulsivity and labile emotional status which has "been very helpful in managing ..." -6/8/23: R3 complained he felt like the vision out of his right eye was not very good. It appeared to him to be 'wobbly or wavy' which had gotten steadily worse over the last few weeks. An ophthalmologic evaluation was indicated as "this could be a retinal injury." -7/7/23: R3 was started on an antidepressant medication to improve his appetite and decrease some of his abusive language toward staff. Pain medications were also adjusted due to complaints of back pain. R3's medical provider notes lacked documentation R3's provider was involved in a comprehensive fall risk assessment/analysis process related to R3's numerous falls. R3's medical record identified R3's fall risk was assessed on 1/5/23, 4/11/23, and 7/7/23 based on the MDS process; however, the record lacked comprehensive fall risk assessment analysis' were completed after R3's multiple falls to develop, adjust, and/or monitor for effectiveness of individualized care plan interventions, to mitigate R3's fall and/or fall injury risk, which were based on his high fall risk factors identified in the fall risk assessments and in the progress notes. During interview on 7/14/23 at 11:59 a.m., licensed practical nurse (LPN)-A stated when a resident fell the resident was to be assessed, a fall huddle conducted to review the fall and	2 830		

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2 830	Continued From page 15 determine if there was anything that could have been done differently, and to implement any new interventions if applicable to prevent further falls; however, she explained "usually after a couple falls" interventions would be implemented "within a week" and if the resident fell "too many times" or if there was an imminent need the provider would be called right away to "get an order for something." She stated any fall intervention was expected to be place on the care plan. LPN-A stated R3 was "a major fall risk" due to continued unsteady self-transfers with "too many falls," significant impulsivity, and fluctuations in his cognitive status where he lacked cognition to understand his fall risk. She identified R3's fall interventions were as follows: alarms, anti-roll back breaks, pain management, keep him busy, alarm checks each shift to ensure function, and attempts to keep him closer to her with extra rounds to check on him which she completed per her own choice. She explained R3 enjoyed staying busy, liked social interaction, and occasionally placed his feet on his w/c when he laid across the bed. She denied R3 utilized a toileting plan and was unsure as to why; however, she explained "he has always been pretty good about asking [to go to the bathroom]." She denied any recent changes to R3's fall interventions and was unsure of any interventions she would implement that potentially would decrease R3's fall risk. During observation on 7/14/23 at 2:09 p.m., R3 laid in bed appropriately with his eyes open. His room was situated directly across from one side of the nurse's station. When approached he quickly uncovered himself and sat up at the edge of the bed. Staff seated at nurses' station were alerted by surveyor as he appeared as if he was going to self-transfer to the w/c situated right next	2 830		

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2 830	Continued From page 16 to the edge of his bed. The w/c breaks were engaged, and he utilized gripper socks. As he stood up and staff situated themselves next to him the bed alarm engaged. He demonstrated an unsteady transfer to the w/c in which staff provided contact guard (hands on) assist. A standard call-light was located at the head of the bed, anti-roll breaks were in place on the w/c, a standard mattress was in place and the bed was positioned at a standard height, a commode frame was over his toilet, and signs on the wall next to the bed and in the bathroom on the wall across from the toilet encouraged him to lock his breaks. The signs did not direct him to wait and call for help. Once in w/c, staff placed shoes with Velcro closures on him. R3 was free of pain indicators; however, he displayed cognitive impairments and asked surveyor if she was going to go babysitting. When interviewed on 7/14/23 at 2:14 p.m., NA-C stated she utilized the NA group sheets, kept at the nurse's station, for resident need(s) information and fall risk interventions; however, she "just kind of knows" what the resident needs are and what the fall interventions were. She explained she was expected to follow the plan of care/NA group sheets and the managers were very good at emailing updates to staff. She considered R3 to be a fall risk as he was constantly up and down in which he was very busy and was known to take off the alarms and/or unplug them. He preferred staff not watch him, or help him, while he toileted and his cognitive status fluctuated. If staff heard the alarms, they knew he was in the bathroom, and they would then stand close and provide any assist he allowed or he "pretty much" informed them when he needed the bathroom. She denied R3 utilized a toileting plan; however, at the end of the	2 830		

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2 830	Continued From page 17 interview when she was asked to show where the group sheets were kept, she reviewed R3's group sheet information and confirmed he had a toileting plan in place. NA-C stated she attempted to keep R3 closer to the nurse's station, attempted to keep his door open when he was in there, and always looked in his room when she walked by to help mitigate falls. She explained the only intervention that would stop his falls would be 1:1 supervision and was unsure of any other interventions to help mitigate R3's falls and/or fall risk. She denied management staff involved her in any fall analysis and/or intervention conversations. During interview on 7/14/23 at 2:39 p.m., LPN-B stated staff were not provided a lot of specific details about the residents; however, they were expected to follow the NA group sheet in which staff are supposed to review the sheets before starting their shift. LPN-B considered R3 to be a fall risk in which it was hard to know when R3 was going to fall. LPN-B stated R3 utilized alarms; however, the alarms agitated R3 when he "moved back and forth." Despite this, the alarms were required to help alert staff when he transferred, or moved around, so they could assist as soon as possible with whatever R3 needed. LPN-B explained communication amongst the nurses had occurred related to the alarm agitation; however, he denied he relayed this information to management. LPN-B denied management asked for his input into R3's falls or thoughts on fall interventions. He explained keeping R3 from falling could not be avoided as "things just happen" but he stated a comprehensive group discussion would be required to come up with interventions and build a solid frame to address R3's fall risk and his status fluctuations.	2 830		

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2 830	Continued From page 18 When interviewed on 7/14/23 at 3:10 p.m., NA-D stated she was expected to follow the NA group sheet for fall interventions and care needs. She explained R3 was a fall risk and already that shift he had been "up and down from bed five to six times" as R3 was a "very confused busy guy." She explained she attempted to keep him busy, such as rummaging through his drawers or listening to music which he seemed to enjoy, while also trying to keep him located nearby with more 1:1 supervision. R3 required toileting every two hours and was not very good at alerting staff of his needs. In addition, he liked to lay in bed with his legs up on the w/c seat. Anti-roll breaks were utilized, along with alarms which did not appear to bother him. NA-D identified R3's fall risk may be decreased if he was involved in more 1:1 activity, assisted to listen to his preferred music, or engaged in conversation about his native American heritage as he liked when staff provided him with "attention." She confirmed she did not communicate these suggestions with activity or any other staff and denied management staff involved her in any fall analysis and/or intervention conversations. During interview on 7/14/23 at 3:25 p.m. activity aide (AA)-A stated she was not aware of details surrounding any of R3's falls or the extent of how often R3 fell. She stated R3 was not provided 1:1 sessions with activity staff and overall, they just invited him to activities; however, he was not one to typically stick around. If they had spare time and encountered him in the hallway or in his room, they would interact with him. She denied staff had approached her to update her about potential activity involvement to decrease his fall risk nor involved her in any fall analysis and/or	2 830		

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2 830	Continued From page 19 intervention conversations. On 7/17/23 at 10:50 a.m., during a telephone interview, R3's family member (FM)-A stated she was invited to two care conference to talk about R3. She was able to attend one and another family member attended the other. No additional conferences have occurred. She denied being involved in any discussion related to R3's falls or to get her intake on possible interventions. She was aware R3 frequently fell, and she indicated R3 required alarms to alert staff when he self-transferred. She believed R3's falls were related to his dementia process. She explained staff adjusted his medications related to his behaviors and performed lab work, but otherwise she was unsure what interventions were in place to mitigate falls. She stated she expected R3 would be on a toileting plan as he had a history of frequency and she further expected staff kept him busy and distracted as he always liked to play with, fiddle with, or straighten things up in his garage. He enjoyed smoking and talking on the phone, he also found comfort with animals, and always kept himself busy. FM-A stated R3 had a longer standing history of vertigo which may also be a factor which increased his fall risk. She stated she had a phone call from staff on 7/14/23 and she expressed her concern related to that; however, she was unsure what the staff did with that information. On 7/17/23 at 10:56 a.m. the clinic for R3's medical provider was called. Receptionist staff stated the provider was out of clinic until 7/19/23; however, a message would be relayed to him that day to return a call. At the time of the exit conference, the provider had yet to response to the message and thus was not interviewed.	2 830		

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2 830	Continued From page 20 When interviewed on 7/17/23 at 12:04 p.m. activity aide (AA)-B stated she was currently the acting interim activity director. She stated she was not aware of the extent of R3's falls or details surrounding his falls as she did not attend the morning's interdisciplinary team (IDT) meetings. She identified currently no one was represented from activities in this meeting. She denied anyone from nursing approached her to involve her in any fall analysis and/or intervention conversations; however, after she talked with AA-A following her interview on 7/14/23, they talked about setting R3 up to participate in a smaller men's sensory group that met once a week and some other potential interventions as R3 was a very busy man in which he liked to stand up and go through his pockets. During interview on 7/17/23 at 12:33 p.m. the DON stated fall assessments were completed with the MDS process i.e., on admission, quarterly, annually, significant change in status and denied they were completed at any other times. Once completed, the care plan was to be updated with information based on the assessment. If a resident fell, she expected staff to follow the fall protocols which included a fall huddle and fall intervention(s) implementation. The IDT then meet three times a week and discussed the falls that occurred, reviewed the incident reports, ensured they were completed as expected, and revised and/or implemented additional fall interventions. She explained this process would be documented either in the progress notes and/or on the incident report (FSI). If documentation was not found in either of these two areas, she would assume this expectation was not followed. The DON explained intervention revision and/or initiation was important to prevent continued falls, injury, or death. She stated R3 had numerous falls in which	2 830		

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2 830	Continued From page 21 he initially had anti-roll breaks on his wheelchair, along with alarms in bed and w/c. Initially, R3 would unhook these and remove them from the bed or w/c; however, he currently left them alone. In addition, initially the anti-roll brakes malfunctioned, and he was provided a new w/c and brakes; however, they were not a success as he continued to have more falls. R3 initially worked with PT but his dementia and follow through was not good. Signs were placed in his room but "the signs do not work," "It is just another intervention," that she was hopeful worked for him. With R3's fall on 7/16/23, staff recommended a toileting plan; however, because this was already inplace, she added, this morning, a section in POC (plan of care NA documentation section in electronic medical record) where staff were required to document toileting every two hours. A PT referral was also requested as R3 seemed weaker. In addition, R3's room was by the nurse's station and discussions were had with his primary provider about his behavioral medications and adjustments were made. She acknowledged R3 experienced periods of dizziness with orthostatic hypotension but was unsure if R3's provider was aware of this risk. She explained R3 no longer utilized the sandals and currently used shoes with Velcro closures which he did not like tight. She stated they seemed to fit him well but was unsure if they were ever assessed for proper fit. The DON was unsure if R3's falls were ever comprehensively analyzed. She stated a quality safety committee met and discussed falls. She was unable to remember exact details related to last week's meeting but felt R3's falls were discussed. She was unable to provide meeting minutes as she explained no one took notes during the meeting. When interviewed on 7/17/23 at 4:10 p.m. the	2 830		

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2 830	Continued From page 22 administrator stated he was part of the organizations fall committee which met once a month. During this meeting staff talked about all the falls that occurred and overall completed root cause analysis on each one. They also looked for trends and areas of opportunity to improve. He identified R3 was discussed at these meetings; however, was unable to provide specific details related to R3. Fall Committee meeting minutes were requested; however, none were provided. A Falls and Fall Prevention policy, undated, indicated the facility's goal was to prevent and reduce as many falls as possible while the resident's independence was optimized, and they were provided individualized resident centered care. The policies Procedure - Fall Prevention section directed nursing to complete an initial assessment of the resident and identify risk for falls and to implement a care plan based on the resident's assessment, history of falls, use of physical assistance equipment, and physician orders. In addition, the policy directed a post fall follow-up to be conducted to learn the circumstances surrounding the fall and for the nurse to complete the nurse's portion of the FSI. The policy lacked direction related to additional fall risk assessments and subsequent analysis', expectations for fall intervention initiation after a fall, and/or processes if a resident experienced multiple falls. The FSI lacked an area within the nurse portion of the report to document intervention information after the fall. The Fall Huddle section asked for information related to "What was different THIS time." The report only indicated an area for steps/actions planned within the Falls Team	2 830		

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2 830	Continued From page 23 Meeting Notes which was completed during the IDT review process. A Care Plan Procedure, undated, identified its purpose was to provide each resident with an individualized care plan that was developed following the initial and comprehensive assessment which assisted the resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being. The procedure directed the plan of care would be periodically updated to provide for increased quality and continuity of care between all care disciplines and staff. In addition, all staff were expected to follow the plan of care unless the resident exercised their right to refuse or had significant changes that prohibited the completion of the care plan. The care plan was expected to include interventions specific enough to guide the provision of care and be updated based on assessments, changes in condition, physician orders or other IDT recommendations. A Resident Assessment policy, undated, identified it was designed to assure current, comprehensive assessment of each resident's needs. A section labeled Falls Assessment directed this to be completed within the first assessment reference date (ARD) of the MDS process, after admission, quarterly, annually, and with a significant change in status. [All based on MDS process]. A section labeled Interdisciplinary Care Plan identified it was to be updated with changes that occurred between reviews [MDS processes]. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being	2 830		

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2 830	Continued From page 24 implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		