



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 2, 2025

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: CCN: 245148
Cycle Start Date: April 17, 2025

Dear Administrator:

On June 6, 2025, we notified you a remedy was imposed. On June 26, 2025 the Minnesota Department 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 June 20, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 17, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 6, 2025, 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 July 17, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 20, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900

The Estates At St Louis Park LLC

July 2, 2025

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Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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June 6, 2025

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: CCN: 245148
Cycle Start Date: April 17, 2025

Dear Administrator:

On May 15, 2025, we informed you that we may impose enforcement remedies.

On June 2, 2025, the Minnesota Department(s) 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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 17, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 17, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 17, 2025.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 \$13,343, 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 July 17, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At St Louis Park Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 17, 2025. 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:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 October 17, 2025 (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:

tamika.brown@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 tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

The Estates At St Louis Park LLC

June 6, 2025

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

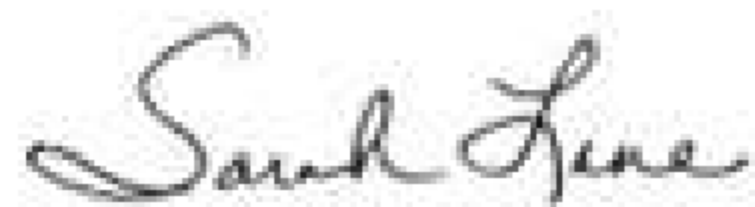
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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June 6, 2025

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

Re: Event ID: 2R5S11

Dear Administrator:

The above facility survey was completed on June 2, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT ST LOUIS PARK LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 5/30/25 - 6/2/25, 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 with no deficiency issued. H51485827C/MN113428. The following complaint was reviewed. H51485608C/MN113322 with a deficiency issued at F684. Deficient practice was identified related to incidental finding at F655. 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 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		6/20/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/16/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 655	<p>Continued From page 1</p> <p>The baseline care plan must-</p> <ul style="list-style-type: none"> (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- <ul style="list-style-type: none"> (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <ul style="list-style-type: none"> (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <ul style="list-style-type: none"> (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to implement the baseline care plan developed for 1 of 3 residents (R2, R3</p>	F 655	<p>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not</p>	

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F 655	<p>Continued From page 2</p> <p>and R4) reviewed. The care plans indicated the residents had cognitive concerns and were to have one-to-one staff care and 15-minute checks. R2 had a fall within hours of admitting to the facility. Upon observation R3 and R4 were not receiving one-to-one cares or 15 minutes checks.</p> <p>Findings include:</p> <p>R2's baseline care plan dated 5/20/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio.</p> <p>R2's nursing progress note dated 5/20/25 at 2:39 p.m. indicated R2 was arrived at the facility at 2:00 p.m. on a stretcher with one emergency medical systems (EMS) person. R2 was 58 years old with a primary diagnosis of glioblastoma (aggressive brain cancer) with recent craniotomy revision (a section of the skull bone is removed to expose the brain for surgery), sepsis (infection of the blood) and diabetic wound with a history of bacteria (bacteria found in the blood stream). He was a fully code (CPR was to be performed). R2 had a PICC (peripherally inserted central catheter) line on his right arm. R2 was at the facility for rehab, physical therapy (PT) and occupational therapy (OT). R2's note did not indicate any safety checks to be performed on R2.</p> <p>R2's admission Minimum Data Set (MDS) dated 5/21/25 was not completed as R2 was admitted to the facility on 5/20/25 and discharged on 5/21/25.</p> <p>Upon interview on 5/30/25 at 3:25 p.m. registered</p>	F 655	<p>constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>Immediate Corrective Action: R2 and R3 have since been discharged from the facility. Examples of safety monitoring (i.e. 15-minute safety checks and 1:1 staff to resident ratio) were removed from R4s care plan immediately.</p> <p>Corrective Action as it applies to others: Facility IDT to review all other residents in the facility to determine if these examples are in their care plan but are not needed interventions at this time. If these examples are listed in a resident care plan and are not appropriate, they will be removed. Social Services and nurse managers will be educated on not including these examples in the care plan unless it applies to the resident and is an intervention the facility has put into place for that specific resident.</p> <p>Date of Compliance: 6/20/2025</p> <p>Recurrence will be prevented by: Audits will be completed on new admissions to ensure that these examples of interventions are not included in their care plan unless it is warranted for the particular resident. Audits will be completed weekly x4 weeks and results shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Any discrepancies will be addressed immediately.</p>	

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F 655	<p>Continued From page 3</p> <p>nurse (RN)-B stated he worked the night shift on 5/20/25. He stated R2 was not a 1:1 or receiving 15-minute safety checks because the facility could not manage that on the night shift as they only staff one nurse and one nursing assistant (NA).</p> <p>Upon interview on 6/2/25 at 10:11 a.m. RN-A reviewed R2's care plan and stated the care plan should not have stated 1:1 care for R2. His care plan was meant to be 15-minute checks. The 15 minutes safety are informal checks completed by all the staff, for example looking in the room, answering call lights, assisting with toileting, or giving medications.</p> <p>R3's baseline care plan dated 5/31/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio.</p> <p>R3's nursing progress notes dated 5/31/25 at 9:00 p.m. indicated R3 admitted from the hospital at 7:43 p.m. on a stretcher by two EMS staff. R3 had a history of left femoral neck fracture, total hip arthroplasty with WBAT (weight bearing as tolerated, Type II diabetes, depression, generalized anxiety. R3 was alert and oriented and continent of bowel and bladder. The note did not indicate any 1:1 care or 15-minute safety checks.</p> <p>R3's MDS dated 6/2/25 was not completed since R3 had admitted on 5/30/25.</p> <p>Upon interview on 6/2/25 at 10:51 a.m. R3 stated she was weak when she stood and has a brain injury therefor since she had not been assessed</p>	F 655	Corrections will be monitored by: DON, Administrator or designee	

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F 655	<p>Continued From page 4</p> <p>by therapy, she should have had 15-minute safety checks. Since her admission staff only entered her room when they brought her meds or meals and when she pressed the call light. She stated she did not recall her care were supposed to be.</p> <p>R4's baseline care plan dated 5/24/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio.</p> <p>R4's nursing progress notes dated 5/24/25 at 2:53 p.m. indicated R4 was admitted to the facility at 2:30 p.m. with two EMS personnels from the hospital. R4 was admitted to the facility due to multiple falls and was at the facility for PT. Per R4's hospital notes R4 was impulsive and did not use his call light. R4 was alert and oriented to himself. The notes did not indicate 1:1 care or 15-minute safety checks.</p> <p>Upon interview on 6/2/25 at 11:08 a.m. R4 stated he was not certain what was supposed to be doing for him. He stated staff came into his room 2-3 times a day to bring him food and medications.</p> <p>Upon continuous observation on 6/2/25 from 11:08 a.m. to 12:33 p.m. R3 and R4 both had their doors closed. At 11:39 a.m. the director of nursing (DON) and the social worker (SW) entered R3's room. The DON exited her room at 11:42 and the SW exited at 11:50 a.m. At 12:25 p.m. R3 walked out of her room with her walker as the food cart was coming down the hall. She turned around and went back into her room. R3's meal was delivered to her room at 12:33 p.m. No</p>	F 655		

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F 655	<p>Continued From page 5</p> <p>staff entered R4's room during the observation period. His meal was delivered at 12:40 p.m. R3 and R4 were not receiving 1:1 care or 15-minute safety checks.</p> <p>Upon interview on 6/2/25 at 12:16 p.m. nursing assistant (NA)-A stated the transitional care unit which housed R2, R3, and R4 did not have any residents with 1:1 care 15-minute checks. He stated the only time had a worked with 15-minute safety checks was when residents were combative with each other, otherwise safety checks were every two hours. The checks were the when the NA's rounded the unit, provided visualization of the residents, repositioned the residents or check and changed incontinent briefs. He stated he had not had a 1:1 resident in years at the facility.</p> <p>Upon interview on 6/2/25 at 1:18 p.m. the Social Worker stated she was not certain how 1:1 care or 15-minute checks got on the care plans.</p> <p>Upon interview on 6/2/25 at 1:30 p.m. RN-C stated the unit did not have any 1:1 care or 15-minute safety checks. Upon care plan review, she stated she was not aware the care plans indicated 1:1- or 15-minute checks. If the care plan indicated specific checks, then the facility is required to do what the plan indicated. In addition, it should indicate 1:1 or 15-minute checks, not both. The initial care plan needed to be patient centered and accurate so staff can do their job properly.</p> <p>Upon interview on 6/2/25 at 1:59 p.m. the Administrator stated when the facility staff create a 48-hour care the 1:1 and 15-minute safety checks are an example to use. She stated the</p>	F 655		

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F 655	Continued From page 6 care plan was meant to offer safety checks as needed for new residents. She stated after the 48-hours it should be reviewed and removed if that is not what the facility doing. She did not expect the staff to follow the example on the baseline care plan however the care plan should indicate clear parameters for the safety checks needed. A facility policy titled Baseline Care Plan with a revision date of 8/2017 indicated the interdisciplinary team reviewed the healthcare practitioner's orders and implement a baseline care plan within 48 hours of admission to meet the resident's immediate base care needs, including things as; initial goals, physical orders, nursing orders, dietary orders, therapy services and social services as needed.	F 655		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide fundamental quality of care of professional standards of practice for 1 of 3 residents reviewed for quality of care. R2 had a fall, and the facility was unable to ensure neurological checks (a critical assessment to	F 684	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.	6/20/25

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F 684	<p>Continued From page 7</p> <p>identify any potential damage to the brain and nervous system) had been completed.</p> <p>Findings include:</p> <p>R2's baseline care plan dated 5/20/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio.</p> <p>R2's nursing progress note dated 5/20/25 at 2:39 p.m. indicated R2 arrived at the facility at 2:00 p.m. on a stretcher with one emergency medical systems (EMS) person. R2 was 58 years old with a primary diagnosis of glioblastoma (aggressive brain cancer) with recent craniotomy revision (a section of the skull bone is removed to expose the brain for surgery), sepsis (infection of the blood) and diabetic wound with a history of bacteria (bacteria found in the blood stream). He was a full code (CPR was to be performed). R2 had a PICC (peripherally inserted central catheter) line on his right arm. R2 was at the facility for rehab, physical therapy (PT) and occupational therapy (OT). R2's note did not indicate any safety checks to be performed on R2.</p> <p>R2's incident note dated 5/20/25 at 10:43 indicated R2 was found seated on the floor less than five minutes after two nursing assistants and the nurse offered to help him use the bathroom. R2 stated he was trying to stand up to use the bathroom. He denied pain, hitting his head and had no injury. R2's vital signs were; blood pressure 145/98 (normal 120/80), pulse 85 (normal 60-100), respirations 18 (normal 12-20), oxygen saturation was 96% on room air (normal</p>	F 684	<p>Immediate Corrective Action: R2 was discharged from the facility on 5/21/2025.</p> <p>Corrective Action as it applies to others: Facility IDT to review resident's who have a fall to ensure neuro checks were started as appropriate for unwitnessed falls or falls with head strike. Education will be completed with all nurses on the importance of initiating neuro checks following an unwitnessed fall or confirmed head strike immediately.</p> <p>Date of Compliance: 6/20/2025</p> <p>Recurrence will be prevented by: Audits will be completed on neuro checks being completed following an unwitnessed fall or fall with confirmed head strike weekly x4 weeks and results shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Any discrepancies will be addressed immediately.</p> <p>Corrections will be monitored by: DON, Administrator or designee</p>	

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F 684	<p>Continued From page 8</p> <p>92% - 100%), pain 0/10 (0 being no pain and 10 being great pain). Under the heading hit head title on the document (initiate neuro-checks for head bump) indicated R2 did not hit his head. A voice mail was left for the on-call provider. The immediate action that took place was to lower the bed and re-educated R2 on using the call light and placed his telephone within reach. The note did not indicate what R2 was doing prior to the fall, where he fell from or what his immediate or follow-up neuro-checks indicated.</p> <p>R2's nursing note dated 5/21/25 at 10:10 a.m. indicated R2 was found seated on the floor of his room, when asked he stated, "I was trying to go to the bathroom and fell." R2 denied hitting his head, no injury was noted at that time. Neuro check sheet was started. R2 was reeducated on using the call-light. The note was documented the morning following the fall and after he went to the hospital.</p> <p>R2's nursing note dated 5/21/25 indicated R2 was sent to the emergency department (ED) around 9:00 a.m. related to a fall. The Family called emergency medical services (EMS).</p> <p>R2's admission Minimum Data Set (MDS) dated 5/21/25 was not completed as R2 was admitted to the facility on 5/20/25 and discharged on 5/21/25.</p> <p>R2's electronic Medical Administration Record (EMAR) dated 5/21/25 at 6:00 a.m. indicated to complete neuro sheet as applicable for three days. This was initiated 7 hours after R2's fall.</p> <p>R2's (EMAR) dated 5/21/25 at 6:00 a.m. indicated for staff to make a progress note post fall x72</p>	F 684		

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

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FORM APPROVED
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F 684	<p>Continued From page 9</p> <p>hours, make sure to include any signs of symptoms of injury and effectiveness of new fall interventions every shift for 3 days. This was initiated 7 hours after R2's fall.</p> <p>R2's (EMAR) dated 5/21/25 at 6:00 a.m. indicated post fall vital sign checks every shift for 24 hours. This was initiated 7 hours after R2's fall.</p> <p>R2's (EMAR) dated 5/21/25 at 0700 indicated to monitor R2 for signs and symptoms of injury post fall x 72 hours. This was initiated 8 hours after R2's fall.</p> <p>R2's (EMAR) dated 5/21/25 did not indicate any neuro-checks to be completed after R2's fall.</p> <p>A written statement to the facility on 5/22/25 by RN-B indicated: Taking care of R2 was very exhausting R2 was demanding and time consuming. He was verbally aggressive, arrogant, loud, and condescending, talking down to staff during cares. "You guys don't know what you are doing." FM-B was present all night and witnessed R2's ranting and even shouting at her. All R2 wanted to do all night was Eat! Eat! Eat! He was constantly demanding more food, one after another enabled by FM-B. FM-B came to the nurses desk for multiple things one after the other, asking for help including more food for R2. She asked for help with him to the bathroom, RN-B helped him to the bathroom when the NA was on a break and for some reason R2 was pretending he was not able to walk/stand. That night NA was in his room multiple times either doing cares, delivering food, or fixing R2's incontinent brief. Between RN-B and NA-A R2's needs and wants were addressed to the best of their ability. Trying to do vital signs on R2 and</p>	F 684		

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F 684	<p>Continued From page 10</p> <p>administer his IV antibiotics was time consuming because he wanted to do something else instead. RN-B's statement did not include the assessments he provided for R2's behavior and post fall. RN-B did not document R2's behaviors in the progress notes.</p> <p>Upon interview on 5/30/25 at 12:15 p.m. R2's family member (FM)-A stated she had not heard from R2 for a few hours on 5/20/25. At approximately 10:45 p.m. she called his room and did not receive an answer. She then called the reception area to ask for staff to check on R2. She was on the phone and registered nurse (RN)-A stated R2 was on the floor, and he was looking for staff to assist him to get him up with the mechanical lift. She stated she was worried because the staff were unable to provide information on how he fell to her over the phone. R2 was a fall risk due to his brain cancer and recent surgery, therefor he was to be closely monitored. FM-A called FM-B and asked her to go to the facility to see R2 and stay with him until the morning until the family could speak with the facility. FM-B got to the facility at approximately 12:30 a.m. FM-B was concerned about R2 as she noticed he appeared short of breath, confused, and combative. FM-B was told the facility conducts 15-minute neuro-checks for the first hour following a fall, 30 minutes for the next hour and then hourly for 24 hours. FM-B stated the staff were not completing half hour or hourly checks when she was there. FM-B had to go out and get staff at the desk when R2 needed assistance because the staff did not answer the call light. Another family member, FM-C, arrived at the facility on 5/21/25 at approximately 8:00 a.m.</p>	F 684		

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F 684	<p>Continued From page 11</p> <p>Upon interview on 5/30/25 at 1:31 p.m. RN-C the nurse manager stated she spoke with FM-C the morning after R2's fall. FM-C stated R2 was to be a 1:1 with his cares as he was in the hospital. RN-C stated she re-read the hospital discharges notes and did not find an order to indicate R2 was to be a 1:1 for cares. FM-C requested documentation of what cares were performed following R2's fall including his neuro-checks. FM-C was told the nurse on duty puts batch orders (the facility fall protocol) into the residents electronic chart, so the staff are sure to complete all the post fall assessments. RN-C stated the neuro-checks can be documented on a hard copy instead in the electronic chart. RN-C could not locate the neuro-checks at the time of the survey. The morning of 5/21/25 RN-C attempted to complete a risk assessment for R2 around 8:30 a.m. however the family would not allow her to and was wanting R2 to be sent to the hospital. The family called EMS.</p> <p>Upon interview on 5/30/25 at 3:10 p.m. RN-A stated he worked and completed R2's admission on 5/20/25. He stated two nursing assistants had asked R2 if he wanted assistance to the bathroom moments before he found R2 on the floor. He was walking past R2's room and found him seated on the floor. He stated R2's wife was on the phone with him. RN-A told FM-A R2 was on the floor, and he was getting assistance and a mechanical lift. About 40 minutes after the fall, FM-C arrived at the facility and stayed the night with R2. RN-A stated he started a hard copy of a neuro-flow sheet and completed the first three neuro-checks. RN-A reported the fall and left the neuro-check sheet for RN-B, the incoming night nurse.</p>	F 684		

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F 684	<p>Continued From page 12</p> <p>Upon interview on 5/30/25 at 3:25 p.m. RN-B stated he worked the night shift on 5/20/25 and referred to it as a "crazy night" stating FM-C was "in his face" all night with questions about R2. He stated he came to work the following day and heard the family had complained that no staff were in R2's room all night. His response was he took R2 to the bathroom when the NA-A was busy. In addition, he hung R2's IV medication and completed his admission vital signs, which were every 4 four hours for the first 24 hours. When prompted about R2's fall RN-B stated the fall happened on the evening shift, so all the fall evaluations were completed at that time. He stated he could not recall if the neuro-checks were still ongoing into the night, if they were he completed them on a hard copy sheet.</p> <p>NA-A was not available for an interview during the survey.</p> <p>Upon interview on 6/2/25 at 8:49 a.m. FM-C arrived at the facility on 5/21/25 due to concerns RM-B called and informed her of. FM-C observed R2's mental status to be altered, increased confusion and anxiety along with grabbing his head. FM-C requested post fall documentation, especially concerned with R2's neuro-checks. The staff could not provide the neuro checks. FM-C was given copies of R2's vital signs taken 5/20/25 at 2:34 p.m., 5/20/25 at 8:01 p.m. (these were before the fall), 5/20/25 at 11:03 p.m. (this was right after the fall), 5/21/25 at 12:47 a.m. and 5/21/25 at 4:03 a.m. and R2's incident fall note from 5/20/25 at 10:43 p.m. FM-C was concerned about R2's neurological status. She called EMS around 9:00 a.m.</p> <p>Upon interview on 6/2/25 at 1:59 p.m. the</p>	F 684		

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F 684	<p>Continued From page 13</p> <p>Administrator expected staff to follow the facility protocol for falls. She was not certain what documentation was completed post-fall for R2.</p> <p>An email request dated 6/2/25 at 3:16 p.m. sent to the Administrator requesting R2's neuro-checks. None were provided.</p> <p>A policy regarding neuro-checks was requested however none was provided.</p> <p>A facility policy titled falls with a revision date of 2/20/25 indicated: Fall occurs:</p> <ol style="list-style-type: none"> a. When a resident has fallen, or is found on the floor, nursing staff will provide comfort, but not move the resident until evaluated for injury. b. The nursing staff will record vital signs (including orthostatic BP), when appropriate. c. If a bump to the head is suspected or confirmed complete neuro checks and update the provider timely. Nursing should utilize the neuro flow sheet per policy. d. If resident is noted to be on a blood thinning medication and sustains a fall there is significant risk of bleeding. This should be reported to the provider in a timely manner. e. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. If a fracture is suspected, do not move resident, but stay with resident and wait for instructions from medical provider or for emergency medical staff to arrive. e. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. f. Nursing staff will notify the resident's medical provider and family in an appropriate time frame. 	F 684		

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F 684	<p>Continued From page 14</p> <p>When a fall results in a significant injury or condition change, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, nursing staff will notify the practitioner routinely (e.g., by fax, phone, or in-house communication book, the next office/visit day).</p> <p>g. Nursing staff will observe for delayed complications of a fall for (72) hours after an observed or suspected fall and will document findings in the medical record.</p> <p>h. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings.</p> <p>i. Nursing staff will complete an incident review and analysis.</p> <p>2. Defining Details of Falls:</p> <p>a. After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred, where it occurred and what the individual was trying to do at the time the fall occurred.</p> <p>3. Identifying Causes of a Fall or Fall Risk:</p> <p>a. Nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairments, etc.</p> <p>b. Staff will evaluate chains of events or circumstances preceding a recent fall, including:</p> <ol style="list-style-type: none"> 1) Time of day of the fall; 2) What the resident was doing or attempting to do; 3) Whether the resident was standing, walking, reaching, or transferring from one position 	F 684		

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F 684	Continued From page 15 to another; 4) Whether the resident was among other persons or alone; 5) When was the last time the resident was repositioned or toileted; 6) Time of the last meal; 7) Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or 8) Whether there is a pattern of falls for this resident. c. The interdisciplinary team will review falls daily at morning meeting. d. The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause cannot be found. e. As indicated, the attending physician may examine the resident or may initiate testing to try to identify causes. f., when possible, the attending physician or nursing staff will document the basis for identifying specific factors as the cause. g. If the cause of a fall is unclear, the fall has a significant medical cause such as a transient ischemic attack or an adverse drug reaction (ADR), or if the resident continues to fall despite attempted interventions, the nursing staff will discuss the situation with the attending physician or Medical Director. h. If causes of a fall cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion, lethargy, restlessness), the staff and physician will consider a possible underlying acute medical cause.	F 684		

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F 684	<p>Continued From page 16</p> <p>Based on interview and record review the facility failed to provide fundamental quality of care of professional standards of practice for 1 of 3 residents reviewed for quality of care. R2 had a fall, and the facility was unable to provide documentation that neurological checks (a critical assessment to identify any potential damage to the brain and nervous system) had been completed.</p> <p>Findings include:</p> <p>R2's baseline care plan dated 5/20/25 indicated safety monitoring would be implemented as needed to ensure residents safety, (i.e.) 15-minute safety checks and 1:1 staff to resident ratio etc.</p> <p>R2's nursing progress note dated 5/20/25 at 2:39 p.m. indicated R2 arrived at the facility at 2:00 p.m. on a stretcher with one emergency medical systems (EMS) person. R2 was 58 years old with a primary diagnosis of glioblastoma (aggressive brain cancer) with recent craniotomy revision (a section of the skull bone is removed to expose the brain for surgery), sepsis (infection of the blood) and diabetic wound with a history of bacteria (bacteria found in the blood stream). He was a full code (CPR was to be performed). R2 had a PICC (peripherally inserted central catheter) line on his right arm. R2 was at the facility for rehab, physical therapy (PT) and occupational therapy (OT). R2's note did not</p>	F 684		

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F 684	<p>Continued From page 17</p> <p>indicate any safety checks to be performed on R2.</p> <p>R2's incident note dated 5/20/25 at 10:43 indicated R2 was found seated on the floor less than five minutes after two nursing assistants and the nurse offered to help him use the bathroom. R2 stated he was trying to stand up to use the bathroom. He denied pain, hitting his head and had no injury. R2's vital signs were; blood pressure 145/98 (normal 120/80), pulse 85 (normal 60-100), respirations 18 (normal 12-20), oxygen saturation was 96% on room air (normal 92% - 100%), pain 0/10 (0 being no pain and 10 being great pain). Under the heading hit head title on the document (initiate neuro-checks for head bump) indicated R2 did not hit his head. A voice mail was left for the on-call provider. The immediate action that took place was to lower the bed and re-educated R2 on using the call light and placed his telephone within reach. The note did not indicate what R2 was doing prior to the fall, where he fell from or what his immediate or follow-up neuro-checks indicated.</p> <p>R2's nursing note dated 5/21/25 at 10:10 a.m. indicated R2 was found seated on the floor of his room, when asked he stated, "I was trying to go to the bathroom and fell." R2 denied hitting his head, no injury was noted at that time. Neuro check sheet was started. R2 was reeducated on using the call-light. The note was documented the morning following the fall and after he went to the hospital.</p> <p>R2's nursing note dated 5/21/25 indicated R2 was sent to the emergency department (ED) around 9:00 a.m. related to a fall. The Family called emergency medical services (EMS).</p>	F 684		

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F 684	<p>Continued From page 18</p> <p>R2's admission Minimum Data Set (MDS) dated 5/21/25 was not completed as R2 was admitted to the facility on 5/20/25 and discharged on 5/21/25.</p> <p>R2's electronic Medical Administration Record (EMAR) dated 5/21/25 at 0600 indicated to complete neuro sheet as applicable for three days. This was initiated 7 hours after R2's fall.</p> <p>R2's (EMAR) dated 5/21/25 at 0600 indicated for staff to make a progress note post fall x72 hours, make sure to include any signs of symptoms of injury and effectiveness of new fall interventions every shift for 3 days. This was initiated 7 hours after R2's fall.</p> <p>R2's (EMAR) dated 5/21/25 at 0600 indicated post fall vital sign checks every shift for 24 hours. This was initiated 7 hours after R2's fall.</p> <p>R2's (EMAR) dated 5/21/25 at 0700 indicated to monitor R2 for signs and symptoms of injury post fall x 72 hours. This was initiated 8 hours after R2's fall.</p> <p>R2's (EMAR) dated 5/21/25 did not indicate any neuro-checks to be completed after R2's fall.</p> <p>A written statement to the facility on 5/22/25 by RN-B indicated: Taking care of R2 was very exhausting R2 was demanding and time consuming. He was verbally aggressive, arrogant, loud and condescending, talking down to staff during cares. "You guys don't know what you are doing." FM-B was present all night and witnessed R2's ranting and even shouting at her. All R2 wanted to do all night was Eat! Eat! Eat!</p>	F 684		

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F 684	<p>Continued From page 19</p> <p>He was constantly demanding more food, one after another enabled by FM-B. FM-B came to the nurses desk multiple things one after the other, asking for helpe including more food for R2. She asked for help with him to the bathroom, RN-B helped him to the bathroom when the NA was on a break and for some reason R2 was pretending he was not able to walk/stand. That night NA was in his room multiple times either doing cares, delivering food or fixing R2's incontinent brief. Between RN-B and NA-A R2's needs and wants were addressed to the best of their ability. Trying to do vital signs on R2 and administer his IV antibiotics was time consuming because he wanted to dosomething else instead. RN-B's statement did not include the assessments he provided for R2's behavior and post fall. RN-B did not document R2's behaviors in the progress notes.</p> <p>Upon interview on 5/30/25 at 12:15 p.m. R2's family member (FM)-A stated she had not heard from R2 for a few hours on 5/250/25. At approximately 10:45 p.m. she called his room and did not receive an answer. She then called the reception area to ask for staff to check on R2. She was on the phone and registered nurse (RN)-A stated R2 was on the floor, and he was looking for staff to assist him to get him up with the mechanical lift. She stated she was worried because the staff were unable to provide information on how he fell to her over the phone. R2 was a fall risk due to his brain cancer and recent surgery, therefor he was to be closely monitored. FM-A called FM-B and asked her to go to the facility to see R2 and stay with him until the morning until the family could speak with the facility. FM-B got to the facility at approximately 12:30 p.m. FM-B was concerned about R2 as she</p>	F 684		

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F 684	<p>Continued From page 20</p> <p>noticed he appeared short of breath, confused, and combative. FM-B was told the facility conducts 15-minute neuro-checks for the first hour following a fall, 30 minutes for the next hour and then hourly for 24 hours. FM-B stated the staff were not completing half hour or hourly checks when she was there. FM-B had to go out and get staff at the desk when R2 needed assistance because the staff did not answer the call light. FM-C arrived at the facility on 5/21/25 at approximately 8:00 a.m. (see her interview below).</p> <p>Upon interview on 5/30/25 at 1:31 p.m. RN-C the nurse manager stated she spoke with FM-C the morning after R2's fall. FM-C stated R2 was to be a 1:1 with his cares as he was in the hospital. RN-C stated she re-read the hospital discharges notes and did not find an order to indicate R2 was to be a 1:1 for cares. FM-C requested documentation of what cares were performed following R2's fall including his neuro-checks. FM-C was told the nurse on duty puts batch orders (the facility fall protocol) into the residents electronic chart, so the staff are sure to complete all the post fall assessments. RN-C stated the neuro-checks can be documented on a hard copy instead in the electronic chart. RN-C could not locate the neuro-checks at the time of the survey. The morning of 5/21/25 RN-C attempted to complete a risk assessment for R2 around 8:30 a.m. however the family would not allow her to and was wanting R2 to be sent to the hospital. The family called EMS.</p> <p>Upon interview on 5/30/25 at 3:10 p.m. RN-A stated he worked and completed R2's admission on 5/20/25. He stated two nursing assistants had asked R2 if he wanted assistance to the</p>	F 684		

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F 684	<p>Continued From page 21</p> <p>bathroom moments before he found R2 on the floor. He was walking past R2's room and found him seated on the floor. He stated R2's wife was on the phone with him. RN-A told FM-A R2 was on the floor, and he was getting assistance and a mechanical lift. About 40 minutes after the fall, FM-B arrived at the facility and stayed the night with R2. RN-A stated he started a hard copy of a neuro-flow sheet and completed the first three neuro-checks. RN-A reported the fall and left the neuro-check sheet for RN-B, the incoming night nurse.</p> <p>Upon interview on 5/30/25 at 3:25 p.m. RN-B stated he worked the night shift on 5/20 and referred to it as a "crazy night" stating FM-B was "in his face" all night with questions about R2. He stated he came to work the following day and heard the family had complained that no staff were in R2's room all night. His response was he took R2 to the bathroom when the NA-A was busy. In addition, he hung R2's IV medication and completed his admission vital signs, which were every 4 four hours for the first 24 hours. When prompted about R2's fall RN-B stated the fall happened on the evening shift, so all the fall evaluations were completed at that time. He stated he could not recall if the neuro-checks were still ongoing into the night, if they were he completed them on a hard copy sheet.</p> <p>NA-A was not available for an interview during the survey.</p> <p>Upon interview on 6/2/25 at 8:49 a.m. FM-C arrived at the facility on 5/21/25 due to concernss RM-B called and informed her of. FM-C observed R2's mental status to be altered, increased confusion and anxiety along with grabbing his</p>	F 684		

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F 684	<p>Continued From page 22</p> <p>head. FM-C requested post fall documentation, especially concerned with R2's neuro-checks. The staff could not provide the neuro checks. FM-C was given copies of R2's vital signs taken 5/20/25 at 2:34 p.m., 5/20/25 at 8:01 p.m. (these were before the fall), 5/20/25 at 11:03 p.m. (this was right after the fall), 5/21/25 at 12:47 a.m. and 5/21/25 at 4:03 a.m. and R2's incident fall note from 5/20/25 at 10:43 p.m. FM-C was concerned about R2's neurological status. She called EMS around 9:00 a.m.</p> <p>Upon interview on 6/2/25 at 1:59 p.m. the Administrator expected staff to follow the facility protocol for falls. She was not certain what documentation was completed post-fall for R2.</p> <p>An email request dated 6/2/25 at 3:16 p.m. sent to the Administrator requesting R2's neuro-checks. None were provided.</p> <p>A policy regarding neuro-checks was requested however none was provided.</p> <p>A facility policy titled falls with a revision date of 2/20/25 indicated:</p> <p>Fall occurs:</p> <ol style="list-style-type: none"> When a resident has fallen, or is found on the floor, nursing staff will provide comfort, but not move the resident until evaluated for injury. The nursing staff will record vital signs (including orthostatic BP), when appropriate. If a bump to the head is suspected or confirmed complete neuro checks and update the provider timely. Nursing should utilize the neuro flow sheet per policy. If resident is noted to be on a blood thinning medication and sustains a fall there is significant 	F 684		

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F 684	<p>Continued From page 23</p> <p>risk of bleeding. This should be reported to the provider in a timely manner.</p> <p>e. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. If a fracture is suspected, do not move resident, but stay with resident and wait for instructions from medical provider or for emergency medical staff to arrive.</p> <p>e. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details.</p> <p>f. Nursing staff will notify the resident's medical provider and family in an appropriate time frame. When a fall results in a significant injury or condition change, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, nursing staff will notify the practitioner routinely (e.g., by fax, phone, or in-house communication book, the next office/visit day).</p> <p>g. Nursing staff will observe for delayed complications of a fall for (72) hours after an observed or suspected fall and will document findings in the medical record.</p> <p>h. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings.</p> <p>i. Nursing staff will complete an incident review and analysis.</p> <p>2. Defining Details of Falls:</p> <p>a. After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred, where it occurred and what the</p>	F 684		

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F 684	<p>Continued From page 24</p> <p>individual was trying to do at the time the fall occurred.</p> <p>3. Identifying Causes of a Fall or Fall Risk:</p> <p>a. Nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairments, etc.</p> <p>b. Staff will evaluate chains of events or circumstances preceding a recent fall, including:</p> <ol style="list-style-type: none"> 1) Time of day of the fall; 2) What the resident was doing or attempting to do; 3) Whether the resident was standing, walking, reaching, or transferring from one position to another; 4) Whether the resident was among other persons or alone; 5) When was the last time the resident was repositioned or toileted; 6) Time of the last meal; 7) Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or 8) Whether there is a pattern of falls for this resident. <p>c. The interdisciplinary team will review falls daily at morning meeting.</p> <p>d. The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause cannot be found.</p> <p>e. As indicated, the attending physician may examine the resident or may initiate testing to try to identify causes.</p> <p>f., when possible, the attending physician or nursing staff will document the basis for identifying specific factors as the cause.</p> <p>g. If the cause of a fall is unclear, the fall has a significant medical cause such as a transient</p>	F 684		

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F 684	Continued From page 25 ischemic attack or an adverse drug reaction (ADR), or if the resident continues to fall despite attempted interventions, the nursing staff will discuss the situation with the attending physician or Medical Director. h. If causes of a fall cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion, lethargy, restlessness), the staff and physician will consider a possible underlying acute medical cause.	F 684			

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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 5/30/25 - 6/2/25 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed during</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/16/25

Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>the survey.</p> <p>H51485827C MN113428 H51485608C MN113322</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		