

Electronically delivered September 19, 2022

Administrator Good Samaritan Ambassador 8100 Medicine Lake Road New Hope, MN 55427

RE: CCN: 245149

Cycle Start Date: August 1, 2022

Dear Administrator:

On August 15, 2022, we notified you a remedy was imposed. On August 30, 2022 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 August 22, 2022.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 30, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 15, 2022, 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 August 30, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 22, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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,

Joanne Simon, Compliance Analyst Minnesota Department of Health Health Regulation Division

Telephone: 651-201-4161

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Electronically delivered

September 19, 2022

Administrator Good Samaritan Ambassador 8100 Medicine Lake Road New Hope, MN 55427

Re: Reinspection Results

Event ID: 7JDU12

Dear Administrator:

On August 30, 2022 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 August 30, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst

Minnesota Department of Health

Health Regulation Division Telephone: 651-201-4161

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Electronically delivered

August 15, 2022

Administrator Good Samaritan Ambassador 8100 Medicine Lake Road New Hope, MN 55427

RE: CCN: 245149

Cycle Start Date: August 1, 2022

Dear Administrator:

On August 1, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 30, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 30, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 30, 2022.

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:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

#### 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 \$11,292; 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 August 30, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Ambassador will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 30, 2022. 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 February 1, 2023 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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@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,

Joanne Simon, Compliance Analyst

Minnesota Department of Health Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 08/29/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	` '	B) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	245149	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	/01/2022	
	AMARITAN AMBASSA	ADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
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F 000	INITIAL COMMENT	ΓS	F 0	000			
	survey was conductive was found to be NC requirements of 42 Requirements for L.  The following composubstantiated: H51493527C (MN0 cited at F689. H51493648C (MN0 cited at F689.	0085399), with a deficiency 0083911), with a deficiency					
	as your allegation of Departments accepted in ePOC, year the bottom of the form. Your electronic be used as verificated.  Upon receipt of an entire onsite revisit of your validate that substated that substated in the policy of	acceptable electronic POC, an refacility may be conducted to intial compliance with the en attained.  azards/Supervision/Devices	F6	889		8/22/22	
	§483.25(d)(2)Each supervision and assaccidents.						
ABORATOR)	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE	

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

Electronically Signed

08/19/2022

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		l \ /	(X3) DATE SURVEY COMPLETED	
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F 689	facility failed to consimplement individual the risk of falls for a reviewed for accide harm for R1 and R and obtained fractures of medical care.  Findings include:  A hospital Discharge 6/30/22, identified if fractures of both hat trauma and osteophon on 7/23/22, at 5:43 identified R1 was a "intercranial hemorneck fracture" followard fracture followard	v and document review, the aprehensively assess and alized interventions to reduce 2 of 3 residents (R1, R2) ents. This resulted in actual 2 who both fell multiple times ares which required emergency be Summary for R1 dated the resident had sustained ands and right foot due to orosis.  Soa.m. a progress note admitted to the hospital with arhage and r (right) femoral wing a fall 7/22/22 at the andicated an admission date of arm anticipated Minimum Data and a fall with a formal wing a fall one staff for mobility R1 was free of range of a her upper and lower accasionally incontinent of bowel ienced a fall with injury in the a fission and a fall with major and was diagnosed with a Alzheimer's Disease,	F 6	R1 and R2 are no longer refacility.  All current residents were refacility.  All current residents were refacility.  All current residents were a to ensure individualized intecurrent and appropriate for a that were found to be at risk addition, residents with 2 or since January 2022 have be by our interdisciplinary team Comprehensive discussion and interventions were compliated interventions were complicted and procedures for Famous and procedures for Famous and procedures for Famous and process is in place for all neand re-admissions to be audited interventions, and care plan process is in place for all neand re-admissions to be audited individualized interventions and ensure comprehensive assessment was completed individualized interventions aplanned upon admission.  Residents that are at risk for audited to ensure a comprehensive assessment and individualizing in place for fall preventions.	eviewed by nart audits for also reviewed erventions were all residents for falls. In more falls een reviewed not all risks pleted by the ocumented in a tool, ats, lized aning. A new ew admissions dited by the iew fall risk ensive I and were care ralls will be hensive zed care plant measures.		
	R1's admission MD	VID-19. Upon hospital return, OS dated 7/6/22, identified R1 tively impaired and required		Audits will be completed we month, monthly for 3 months quarterly thereafter as coord	s and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUIDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	and toileting cares. motion limitations to one lower extremincontinence of boy diagnosed with a rigidischarge return and R1's hospital Dischidentified R1 was discharge return and third metacarpal both The summary direct non-weight bearing and for physical and R1's initial Fall Tool R1 scored 20.0 inditional identified its purpotential falls, possionand reviewed sever falls, medication us cognitive status, "and check list for additional plan. The tool identified its purpotential falls prior to a risk medication, was psychological factor and recently had a safe mobility. In additional mobility transfers a unchecked. R1's action remained unchecked.	assist of two staff for mobility R1 experienced range of both upper extremities and nity, was frequently wel and bladder, and was ght foot fracture and continued atticipated identified diagnosis.  arge Summary dated 6/21/22, iagnosed with a right hand one fracture related to a fall. Sted orders for R1 to be to her right upper extremity doccupational therapy.  completed 6/21/22, identified icating a high risk for falls. The rpose was "To identify risk for ible causes for actual falls, ance for proper interventions ral factors including history of age, psychological and utomatic high risk" status(s), a conal risk factors and an action ified R1 experienced one or admission, received one higher is affected by one or more res, was moderately impaired change in condition affecting dition, the tool identified R1 related to confusion, poor tion, difficulty following continence. The risk factors for and medical remained continuous are referral to plan to update the care plan ed.	F 6	Nurse Manager. Results of reviewed by the Director of trends and/or patterns and i improvement plans. Finding reported to the QA committee valuation and recommendate.	Nursing for mplement gs will be ee for further	
	R1's subsequent Fa	all Tools identified the following				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	additional identified equipment, dement behavior, impaired tools Action Plan se interventions7/1/22: Score of 20 identified risk factor difficulties in oriental indicated a referral Action Plan to update unchecked.  R1's baseline care 6/22/22, identified Family with impaired though Alzheimer's Diseas physical mobility with ambulate or do selfor related to a right har bladder, was diagnouse of antidepressation for falls related to "dincontinence." In action R1's desire to return spouse. The care propose. The care propose. The care propose. The care propose. The care propose and what resident as to fall care environmental haza contribute to falls.  R1's medical recording medical recordi	ge 3  13.0 (medium fall risk) with risk factors (forgets to use ia, impulsive/risk-taking balance or coordination). The ection was unchecked for 0 (high fall risk) with additional is (weight bearing restrictions, ation). The Action Plan to therapy intervention. The ite the care plan remained plan initiated 6/21/22 through R1 was cognitively impaired the process related to e, demonstrated limited the inability to transfer, e-cares without assistance and fracture, was incontinent of osed with COVID-19, required ant medication, and was at risk confusion, history of falls, addition, her care plan identified in to her private condo with her ilan listed several interventions ed R1 required contact guard enting and fall prevention eate resident about safety to do if a fall occurs, educate auses, and review and modify and that could cause or		689		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	as R1 "continually thelp after education of 6/23/22, a progression of ambulate but new someone with her to the dated 6/23/22, idensafety awareness a on call light use durwhen asked what suse the bathroom FOT note indicated Flocate and use call on 6/24/22, a prograble to make need checks due to high diagnosis."  On 6/25/11, a prograble to make need checks due to high diagnosis."  On 6/25/11, a prograble to make need checks due to high diagnosis."  A Found on Floor en 8:25 a.m. identified front of door" with the and tongue with an elbow. R1 stated shoked for someone sent to the hospital the fall, R1 was originally an elbow of the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the fall, R1 was originally and the someone sent to the hospital the someone sent to the someone sent to the hospital the someone sent to the hospital the someone sent to the someone s	afety checks to prevent falls transfer[s] without asking for in."  ress note indicated"[R1] is able eds reminders to have to do so"  erapy (OT) progress note attified R1 was assessed for and received extensive training ring the session; however, whe should do if she needed to R1 stated, "get up and go." The R1 required "max cues to light this date."  ress note indicated R1 was als known, but needs frequent fall risk related to Alzheimer's ress note indicated "Nursing equent checks on [R1] due to ated to) confusion from late	F 68	89		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	(interdisciplinary tea fall. The note indical something and look which R1 failed to use assistance. IDT revolutions and reduced for falls. IDT's plander risk status upon returned R1 was demential and "traused and right foot due to the Associated dischart activity level to constright lower extremitions to two pounds extremities, along work to two pounds extremities, along work to the facilist staff for transfers, the (due to) fall risk," where was noted to reason the facilist of the facilis	dy after R1's fall.  6/27/22, indicated the IDT am) met and reviewed R1's ated R1 stated she heard are defer someone to get her in use her call light to ask for riewed reason for admission, on use, age and R1's high risk was to "re-evaluate patient fall urn from hospital."  arge Summary, dated 6/30/22, iagnosed with COVID-19, on, late onset Alzheimer's matic fractures of both hands or trauma and osteoporosis." ge orders identified R1's sist of non-weight bearing to y and partial weight bearing of for left and right upper with orders for physical and by.  ress note indicated R1 lity. She required assist of one to be "monitored closely d/t as disoriented to time and ction, required oxygen which amove at times, her right lower leg were ace wrapped, to her call light and was on		89		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	A physical therapy 7/7/22, indicated where the seated on the R1 self-transferred triggered and whee was not evidence the related to R1's self-transferred triggered and whee was not evidence the related to R1's self-transfer to R1's self-trans	ess note indicated R1 "was ansfer" and required a full all transfers.  (PT) progress note dated then the PT entered R1's room, the toilet. The note indicated based on call light not elchair not by bathroom. There he PT updated nursing staff transfer.  The ess note indicated R1 was fer in room; safety checks event injury."  The dated 7/14/22, indicated ed R1's room, R1 was noted ther CAM (control ankle ty boot for protection, and hair or walker was in the ele included, R1 "reports walking There was not evidence the graff related to R1's self  The event report dated 7/22/22, at R1 was found on her ered in blood and fecal matter. It is stated she tried to go to slipped. She sustained a skin earm. At the time of the fall, ally to herself with the following blogical factors: confused,	F 68				

<b>,</b> ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			81	REET ADDRESS, CITY, STATE, ZIP CODE  100 MEDICINE LAKE ROAD  EW HOPE, MN 55427	<u>  UO/</u>	01/2022
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F 689	foot.  A subsequent program, indicated R1 was to get out of bed by use her call light to she moved. The profailed to remember  On 7/23/22, at 5:43 identified R1 was as "intercranial hemoraneck fracture."  From 6/22/22 to 7/2 R1's care plan lacked support R1's baseling been assessed/adjusted interventions imfall risk after R1's as self-transfer attempthe facility, and after a higher risk for falls Tool risk factors.  R2's progress notes indicated the resided during the night and to the hospital with A progress note indicated with A progress note indicated the resided during the night and to the hospital with A progress note indicated with R2's admission MD was severely cognitive.	ress note on 7/22/22, at 7:40 vas noted by the nurse "trying herself." Staff reminded her to get staff to be with her before ogress note identified R1 she fell at 6:38 p.m.  a.m. a progress note dmitted to the hospital with hage and r (right) femoral  22/22, prior to her 7/22/22 fall, and documented evidence to the fall interventions having usted, or new individualized plemented to decrease R1's tempted/performed at a state of the	F 6	889			
	extensive assist wit	She required limited to her mobility and extensive She was deemed not steady					

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		245149	B. WING			C 01/2022	
	PROVIDER OR SUPPLIER	ADOR		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
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F 689	walking and transferespiratory failure at falls prior to admissile least one fall without R2's initial Fall Tool R2 scored 20.0 indition for falls. The tool id history; but took two medications, was maffected and moder Check marked risk experienced muscle fatigue, reduced insimemory. The action remained unchecked R2's subsequent Fainformation: -5/15/22: Score of additional identified incontinence). Mobunchecked. The Actional identified (impulsive/risk-takindifficulty following in and coordination). Interventions were incompleted in the Action Plan intervention in the	essist to stabilize her during ers. Diagnosis included acute and pneumonia. R1 was free of sion; however, sustained at ut injury after admission.  completed 5/13/22, identified a cating R2 was at a high risk entified R2 was free of fall to or more higher risk enderately psychologically rately cognitively impaired. Factors identified R2 was was a referral to plan indicated a referral to plan to update the care plan ed.  all Tools identified the following 17.0 (high fall risk) with risk factors (impulsiveness, ility/Transfers status remained tion Plan to update the care 17.0 (high fall risk) with risk factors impulsiveness, in generation, disorientation, estructions, impaired balance No other Action Plan identified.  10.0 (high fall risk) with risk factors (pain, fatigue, earing ability, incontinence). Ervention was a referral to a Plan to update the care plan		89			

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F 689	identified R2 experimpairments related aphasia (difficulty experiormanical mobility are performance related deconditioning, and heart failure where risk care plan ident weakness, decond (decreased oxygen balance, activity into breath. R2's fall risk falls with interventing grabber to pick thin encourage therapy promotion, and ensurable footwear during trallacked individualized decrease R2's risk risks.  R2's medical recording formation:  R2's hospital Acuted dated 5/4/22, identification:  R1's hospital Acuted dated 5/4/22, identification:  R2's hospital Acuted dated 5/4/22, identification:  R2's hospital Acuted dated 5/4/22, identification:  R1's hospital Acuted dated 5/4/22, identification:  R2's hospital Acuted dated 5/4/22, identification:	plan initiated 5/13/22, ienced communication d to dementia and expressive expressing self), a limitation in ad deficits in self-care d to weakness and a diagnosis of congestive she required oxygen. R2's fall ified a fall risk related to itioning, dementia, hypoxia level in tissues), impaired colerance and shortness of k goal was to remain free of ons to remind R2 to use a legs up off of the floor, with exercise activity sure she wore appropriate ensfers. R2's fall risk care planted fall interventions to of falls based on R2's fall didentified the following  Physical Therapy Evaluation ified R2 demonstrated with short term memory recall s", impaired judgement with the wareness, along with strength and activity luation indicated R2 was at risk ed the following interventions: ons, Posey sitter (alarm), system, call light in hand, all		89			

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F 689	A nursing home Fordated 5/15/22, at 6 found on the floor was under her back, he product were pulled (feces) was found indicated at the time only to herself with physiological factor incontinence. The fall intervention was R2's fall.  On 5/15/22, at 7:00 lacked evidence a immediately after her bathroom; how standing up with her bathroom; how standing up with her and she stated she nurse was uncomform.	22 a.m. a hospital nursing rated [R2] experienced "a near on feet"  und on Floor event report rate and identified R2 was with her trash can tipped over rate and incontinence and down to her ankle and stool in the trash can. The report report e of the fall, R2 was oriented the following predisposing rest confused gait imbalance, event report lacked evidence as initiated immediately after  a.m. R2's fall progress note fall intervention was initiated	F 68	89			

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		245149	B. WING		0	C 8/01/2022	
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F 689	made aware that [Retoilet as she is a high forgetful."  A progress note on indicated the IDT mote identified R2 wimpaired cognition awareness and judgher current physical discussed a bedsid R2's demential seven what a commode wapproach was not into perform "frequent on 5/16/22, at 8:39 progress notes indicated out of her room every hour for risk of R2's care plan identified R2's fall risk; however the commoder of the toilet of staff were to check on 5/25/22 a Care identified R2's fall risk; however date for therapy was a plan for her to discare assisted living progress note lacked.	ified "All nursing staff was [2] cannot be left alone on the fall risk and is very [5/16/22, at 3:54 p.m.]  The tand reviewed R2's fall. The was found on the floor and contributed to poor safety gement with lack of insight into a limitations. The IDT is ecommode; however, due to exity and inability to recognize was or its purpose this implemented. IDT's plan was at checks" on R2.  The p.m., on 5/18/22, and 5/20/22 cated R2 "self-transport[ed] in and needs to be monitored of falls."  Tiffied on 5/16/22 the ent checks" was initiated due to owever, R2's care plan lacked that R2 was not to be left or specific details on how often	F 6	89			

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F 689	use her call light or thus staff conducte R2 as "she has fall current stay and is  A Found on Floor et 1:30 a.m. identified bathroom floor. R2 the bathroom and I to have walked to the R2 displayed a "good head, complained of movement, and he the time of the fall, herself with the follophysiological factor imbalance. The everall intervention was fall.  On 5/31/22, at 2:34 identified R2's fall at 1.  On 5/31/22, at 6:56 indicated R2 was at 1.  A hospital shift to stated 6/1/22, indicated R2 was at 1.  A hospital Care Pla R2 was at 1.  A hospital Care Pla R2 was at 1.  R2 was at 1.  A hospital Care Pla R2 was at 1.  A hospital Care Pla R2 was at 1.	ress note indicated R2 did not make her needs known and d frequent safety checks on en numerous times during a high fall risk."  Event report dated 5/31/22, at R2 was found lying on the stated she walked back from ost her balance. R2 appeared he bathroom without a device. Ose egg" on the side of her of severe left hip pain with a left foot was rotated out. At R2 was oriented only to owing predisposing is: confused and gait ent report lacked evidence a initiated immediately after her earn. a progress note did 1:30 a.m.  Is a.m. a progress note dimitted to the hospital with a eumonia, and low magnesium. The was instructed it was time as if R2 was asked if she was in note dated 6/2/22, identified alls in which the following in place: fall risk light on all risk sticker on door, fall	F 6	89		

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F 689	assistance, high risassistive device clossistive preview prescribed repredispose falling, and a hospital Dischargidentified R2 requiritment femur fraction of 6/3/22, a progres R2's status before note identified R2 visecondary to demetest) of 5/30, she wight use was incompattern of self-trans "therefore she is freconfusion and risk confirmed R2's walnext to her bed and light before she self reviewed and follow the incident. The progression of 6/3/22, a new confirmed R2's walnext to her bed and light before she self reviewed and follow the incident. The progression of 6/3/22, a new confirmed R3/22 and fall or with the 6/3/24 and femur fracture assist with mobility identified a fall risk decision making, whistory of falls, admitted the representation of falls, admitter the representation of falls and fall risk decision making, which the representation of falls, admitter the representation of falls and fall risk decision making, which the representation of falls and fall risk decision making, which the representation of falls and fall risk decision making, which the representation of falls and fall risk decision making, which the representation of falls and fall risk decision making and fall risk decision of falls and fall risk decision of falls.	repetitive reminders to ask for sk armband on, hi-lo bed, keep be at all times, bed alarm on, bers, stay within arm's reach h toileting every two hours, medications that could and physical therapy.  The Summary, dated 6/3/22, ed surgery for a left interfecture  The sess note indicated a review of and after her 5/31/22 fall. The was cognitively impaired entia with a SLUMS (cognitive ras incontinent of bladder, call sistent, she displayed a sfers to the bathroom, equently checked due to for falls." In addition, the note ker and wheelchair remained if she did not activate her call f-toileted. The care plan was wed prior to and during time of rogress note lacked evidence as initiated immediately after her		39			

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F 689	pick things up off with exercise active wore appropriate care plan lacked attempts or any a care plan lacked attempts or any a care plan lacked attempts or any a concerns." In add forgetful, restless attempted to self-bathroom and as performed frequesafety.  R2's care plan lacked to self-bathroom and as performed frequesafety.  R2's care plan lacked to self-bathroom and as performed frequesafety.  On 6/16/22, a prodischarge plans wher assisted living services.  On 6/17/22, a prodischarged to her where the services interventions immediately followed until the and either adjusted implemented new frequent check fare "purposefully, one walk down the harmonic plant in the services in the services of the services in the services of the services o	emind R2 to use a grabber to of the floor, encourage therapy vity promotion, and ensure she footwear during transfers. The evidence of R2's self-transfer dditional fall risk interventions.  gress note indicated R2 nitoring due to "safety ition, the note indicated R2 was and called out for help. R2 transfer when she needed the she was a high fall risk staff int checks on her to ensure exceed evidence of her inpts or any additional fall risk gress note indicated R2's vere to discharge on 6/17/22 to a facility with hospice (end of life) or facility with hospice (end of life) assisted living facility.  If on 7/29/22, at 1:56 p.m.  RN)-B stated after a resident ected to develop or revise fall rediately and these were to be fall committee reviewed the fall ed the intervention(s) or ones. RN-B indicated a li intervention meant se every hour, and every time I li I look in. We try to keep the ean if they are a fall risk." RN-B	F 6	89		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 689	lacked a specific tire could check as murindicated R1 experifacility and stated the the foot fracture." Stwo hour toileting portion [R1] knew to check "undocumented unkeep our eyes on how how such approach R1's care plan prior confirmed, on 7/22 witnessed R1 attenshift. She explained she initiated a care hourly safety check RN-B stated R2 was staff were "keeping she was unsure of utilized to help preventions. No scheduled wherever sometimes worked initially familiar with remember details roof time since w	frequent check intervention me frame for the checks staff ch as they wanted. RN-B enced at least two falls in the ne first one "is what caused the stated R1 was on an every lan and "those [staff] that knew on her" and there was an derstanding that we needed to er." She was unable to explain a les) were not initiated into to R1's fall on 7/22/22. She less before R1's fall, she only after R1's 7/22/22, fall plan approach to perform as on R1 as she was a fall risk. It is "a huge fall risk" in which an eye on her." She indicated any other interventions R1		689		

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F 689	every hour to make are every 15 minute She indicated a rescharting, indicated explained she check she could while she frequency fluctuate on the unit that shift.  When interviewed stated she reference know resident need explained an interviewed and interviewed and interviewed and interventions for R1 was unable to identify interventions for R1 was instructed by note to her high fall "every day:" "[R1] of 10 to 15 minutes lated the window not stated on her if you chair you have to go whereabouts."  When interviewed and the window interventions for R1 was aware of R1's verbalized she sust with the first fall and second fall. He den staff conducted to destated during a care talked about her needs and second fall.	d on those residents "usually sure they are okaysome es, some are more or less." sident's care plan, or their the time frame for checks. She ked on R1 as frequently as e helped others, and stated the d based on how busy she was		9			

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F 689	and explained the of from self-transfers of FM-A stated R1 trailife) services on 7/2 management. He exher status; however fall caused her curred. During a telephone a.m. RN-A stated at "fall huddle" and att intervention as a teat This intervention or came RN-A stated she fai interventions were in 7/22/22 however, or getting her to the hoself-transferred which for her." RN-A explain peeking in on her at help prevent falls." In intervention for frequency anyone passed that into the room as the resident doors open "usually we put a nuity an intervention was "pretty vague." was the main place interventions for resident doors open the facility attemptes same units; however they were needed were sidents they were	not supposed to self-transfer only intervention to stop her was to "strap her to a chair." Insitioned to hospice (end of 8/22, after hip surgery for pain explained R1's falls did not help to the help to the highest help to the high high to the highest help to the high to the high high to the high high to the high to the high high high high high high high hi	F 6	89			

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F 689	expected to implement intervention(s) on the she expected all intervention/pespecially given state were needed and neexpected staff reviews sheets for fall interventions frequent check fall or two checking on high fall risk." She sindicated a time fraplan just indicated in "basically interventions frequent checks recollected, on 7/22 updated R1's care supper to decrease During interview on the same to decrease Supper Suppe	rated after a fall staff were nent or adjust fall care plan he shift the fall occurred and terventions which assisted with revention to be care planned, aff were scheduled where they nay not know the resident. She ewed the care plan and group ventions. RN-C identified a intervention meant "every hour them, especially if they are a stated at times the care plan me for the checks or the care frequent checks. She stated ons fall around the reason of of the resident." She explained e-transfer" and followed up: of falls, that is why we had her "RN-C thought she plan to toilet her right after e falls.  8/1/22, at 12:30 p.m. physical A stated R1 was a fall risk boot and her cognition: "[R1] with her cognition she just do it." PTA-A explained R1 ell until she fell" and showed nobility despite her weight PTA-A stated therapy makes for fall risk; however, she of involvement in R1's fall risk te her having been one of R1's	F 6	89			
	manager RN-D sta	on 8/1/22, at 12:57 p.m. care ted she expected after a sort of intervention" was to be					

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F 689	and care planned." were important "so over shift to shift ar care." She explained care planned inform staff and confirmed where they were not they worked with un stated she was involved a medical record's sy which tracked facili process involved a medical record's sy which tracked facili process was based however, overall af committee reviewe only which encomp nurses fall note and notifications and in resident's progress the resident fell free reviewed risk mana progress notes sed to continue with ap denied the committ risk after a resident and explained she completed upon ad and based on the se care planned and in the committee had hospital returns to re	within that [fall] time period Care planned interventions that it [intervention] is carried at it is part of their plan of a dif interventions were not nation would not be relayed to staff were overall scheduled eded and there was a risk familiar residents. RN-D olved in the fall committee through Friday and involved team (IDT). The review review of the electronic stem "Risk Management" ty events (falls). The review on the fall circumstances; ter a residents first fall the difference the fall details, the difference for any and conducted general did not review the notes section or care plan. If quently the committee agement and the resident's tion and the care plan in order proaches or adjust them. She see re-reviewed falls and fall a returned from the hospital expected a Fall Tool to be mission/return and after a fall core and fall history the ed or updated with fall estated a committee review of a hospital return was important and fall risk interventions were mplemented. RN-D confirmed not met after R1 and R2's re-evaluate their falls prior to to ensure the care plan	F 6	89			

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F 689	intervention meant the hall just peeking person is doing In floor or doing all the doing." She denied she expected where checks without a specific enough confirmed R1 and I on their Fall Tool so to self-transfer duri R1's and R2's care interventions to deatheir risk factors and behavior.  When interviewed administrator stated their fall policy and be put into place in was documented/reaction helped with a resident needs and The goal was to proconfirmed she was and explained the ore-reviewing the fall the hospital to ensure and she expected to documented in the someone is a fall riconversation on hostated a frequent or in when walking by	vidualized fall risk stated a frequent check fall "when [staff] are walking down g in the room to see what the naking sure they are not on the ose things they should not be she educated staff on what a care plan indicated frequent becific time frame despite her quent check intervention was a to ensure safety. RN-D R2 were at risk for falls based cores and both were observed ing their stay(s). She stated plans lacked individualized fall crease their fall risk based on and observed self-transferring on 8/1/22, at 1:54 p.m. the dishe expected staff to follow expected a fall intervention to inmediately after a fall which effected in the care plan. This staff communication of assisted to decrease fall risk. Event falls. The administrator involved in the fall committee committee should be a lonce a resident returned from the appropriate interventions the re-review to be resident's chart: "if we know sk we really should have a we to prevent a fall" She heck intervention meant "a pop [a resident room]more than administrator stated R1 and		89			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ADOR		STREET ADDRESS, CITY, STATE, ZIP COE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 689	Continued From pa		F 6	889			
	director of nursing after a resident fell reviewed and then implemented and deplan. Care planned as the care plan director safety. She confirm where needed and were not familiar with frequent checks make their door open walking by to make they do not like the Further, she stated their hall frequently timed checks; how the "realistic" and a on at designated timed of the other DON acknowledged committee. The conviewing the Risk Mand ensured all the completed, or follow explained intervential adjusted based on interventions were implemented, commisted based on interventions.	18/1/22, at 2:19 p.m. the (DON) stated she expected that the care plan was adjusted or a new intervention locumented within the care interventions were important ected resident care and led staff were scheduled worked with residents they with. The DON explained eant, "If a resident allows to en staff just peek in when sure they are in a safe spot. If door open they try to peekin.", "Staff should be circulating." She explained she preferred ever, interventions needed to resident may not be checked me frames depending on the residents at that time. The d she participated in the fall mmittee reviewed falls by an agement event for the fall required components were wed up on when required. She is interviewed and the fall information. If not documented as mittee staff interviewed the fall process for additional explan was updated. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool. She expital return the resident was sk with a Fall Tool.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	COMPLE	(X3) DATE SURVEY COMPLETED	
		245149	B. WING		08/01	/2022	
	PROVIDER OR SUPPLIER  AMARITAN AMBASS		STREET ADDRESS, CITY, STATE, ZIP CO 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (PROVIDER'S PROVIDER'S PROVID	OULD BE	(X5) COMPLETION DATE	
F 689	record lacked docucommittee re-evalureturned on 6/3/22 both R1 (after her return on room closer to the During a telephone p.m. R2's FM-B staupdating him relate however, lacked krin her stay. In addit remember being into fall interventions reminding R2 she button if she needed was no way in hell that." FM-B also sa confused due to he surroundings. FM-6/23/22 after her dishome to the assiste the broken hip she failing to thrive. She gave up."  A facility Falls Resorviewed/revised 3 began with proactivisk factors and proactions to reduce the identification and proactions to reduce the identification in the packet care plan was to be safety. The packet care plan was to be safety.	2/22 fall and confirmed R2's imented evidence the lated her fall risk when she is however, she explained for return on 6/20/22) and R2 (6/3/22) both were moved to a nurse's station.  In interview on 8/1/22, at 3:57 ated he remembered staffed to R2's fall on 5/31/22 howledge R2 had fallen earlier tion, he stated he didn't evolved in discussions related in the stated he witnessed staffer needed to push her call light ed something: "I knew there she was going to remember aid R2 was considerably more ear hospital stay and different B stated R2 passed away on ischarge from the nursing ed living. FM-B stated, "After had what the doctor called e was not eating. She kind of ource Packet-Rehab/Skilled /30/22, indicated fall reduction vely recognizing potential fall beceded with communicated the possibility of falls. Early frompt communication of oid falls was vital for resident directed that after a fall the echecked to determine if the	F 6	889			
		as addressed (to avoid n the same cause). In addition, History at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION ING	, ,	(X3) DATE SURVEY COMPLETED	
		245149	B. WING			C 08/01/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	<u> </u>	00/01/2022
GOOD S	AMARITAN AMBASSA	ADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AF  DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	chart directed if a reassessment was 16 fall risk factors and Tool. After, staff we appropriate residen communicate care review the care plan	ssion/Duration of Stay flow	F 6	89		



Electronically delivered August 15, 2022

Administrator Good Samaritan Ambassador 8100 Medicine Lake Road New Hope, MN 55427

Re: State Nursing Home Licensing Orders

Event ID: 7JDU11

#### Dear Administrator:

The above facility was surveyed on July 29, 2022 through August 1, 2022 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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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,

Joanne Simon, Compliance Analyst

Minnesota Department of Health

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 08/29/2022 FORM APPROVED

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00898	B. WING		08/01/2022			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
GOOD S	GOOD SAMARITAN AMBASSADOR 8100 MEDICINE LAKE ROAD							
0/ A) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	PE, MN 5542	PROVIDER'S PLAN OF CORRECTI	ONI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE			
2 000	Initial Comments		2 000					
	****ATTEN	NTION*****						
	NH LICENSING CORRECTION ORDER							
	144A.10, this correct pursuant to a surver found that the deficit herein are not corrected shall like with a schedule of fithe Minnesota Department.	nether a violation has been						
	requirements of the number and MN Rule When a rule contain comply with any of the lack of compliance. re-inspection with a result in the assess	rule provided at the tag le number indicated below. Its several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was						
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.						
	conducted at your fa Minnesota Departm	S: , a complaint survey was acility by a surveyor from the ent of Health (MDH). Your compliance with the MN						
	The following comp	lainst were found to be						

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE 08/19/22

**Electronically Signed** 

PRINTED: 08/29/2022 FORM APPROVED

Minnesota Department of Health

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00898	B. WING		08/0	01/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAN AMBASSADOR  8100 MEDICINE LAKE ROAD  NEW HOPE, MN 55427						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICITION (CORRECTION CORRECTION CORRECTI	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: and H51493648C (I order was cited at 4	H51493527C (MN00085399) MN00083911) a licensing 658.0520 Subdivision 1.				
	-	ent of Health is documenting Correction Orders using				
	signature is not required, it is required, it is required.	ed in ePOC and therefore a uired at the bottom of the first Although no plan of correction uired that the facility of the electronic documents.				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			8/22/22
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensity of the comprehensive as designed.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on interview facility failed to coming implement individuation the risk of falls for 2	ent is not met as evidenced and document review, the prehensively assess and alized interventions to reduce of 3 residents (R1, R2) nts. This resulted in actual		R1 and R2 are no longer residents facility. All current residents were reviewed Nurse Managers through chart aud fall risks. Care plans were also rev	d by dits for	

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STATE FORM 7JDU11 If continuation sheet 2 of 24

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE SURVEY COMPLETED	
		00898	B. WING		08/01/2022	
NAME OF PROVIDER OR SUPPLIER  STREET ADD  8100 MED			DRESS, CITY, STATE, ZIP CODE  DICINE LAKE ROAD  PE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
2 830	and obtained fractured medical care.  Findings include:  A hospital Discharg 6/30/22, identified to fractures of both hat trauma and osteopo On 7/23/22, at 5:43 identified R1 was ac "intercranial hemore neck fracture" follow facility.  R1's nursing note in 6/21/22.  R1's discharge retured Set (MDS) dated 6/21/22.	e Summary for R1 dated he resident had sustained and right foot due to crosis.  a.m. a progress note dmitted to the hospital with rhage and r (right) femoral wing a fall 7/22/22 at the addicated an admission date of a fall with rhage of a her upper and lower casionally incontinent of bowel enced a fall with injury in the ission and a fall with major ion, and was diagnosed with a Alzheimer's Disease, ID-19. Upon hospital return, and Sale and required assist of two staff for mobility R1 was free of range of a her upper and lower casionally incontinent of bowel enced a fall with injury in the ission and a fall with major ion, and was diagnosed with a Alzheimer's Disease, ID-19. Upon hospital return, and Sale and required and required assist of two staff for mobility R1 experienced range of a both upper extremities and an ity, was frequently well and bladder, and was ght foot fracture and continued	2 830	to ensure individualized interventic current and appropriate for all resistant were found to be at risk for far addition, residents with 2 or more since January 2022 have been resigned by our interdisciplinary team.  Comprehensive discussion on fall and interventions were completed Interdisciplinary team and docume medical record.  Licensed Nurses will be educated 8/16/2022 through 8/22/2022 on fapolicy and procedures for Fall Management including Falls tool, Comprehensive assessments, implementation of individualized interventions, and care planning process is in place for all new admand re-admissions to be audited be Interdisciplinary team to review fascore and ensure comprehensive assessment was completed and individualized interventions were completed and individualized interventions were completed to ensure a comprehensive assessment and individualized cais in place for fall prevention meas Audits will be completed weekly for month, monthly for 3 months and thereafter as coordinated by the Nanager. Results of audits will be reviewed by the Director of Nursing trends and/or patterns and implending improvement plans. Findings will reported to the QA committee for evaluation and recommendations.	idents Ils. In falls viewed risks by the ented in acility  A new hissions by the Il risk care will be re plan sures. or 1 quarterly lurse ented in g for hent be further	
	•	ght foot fracture and continued ticipated identified diagnosis.		evaluation and recommendations		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ADOR 8100 MEI	DRESS, CITY, STORESS,	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	identified R1 was distance third metacarpal both The summary direct non-weight bearing and for physical and R1's initial Fall Tool R1 scored 20.0 inditional identified its purpotential falls, possionand to provide guid and reviewed sever falls, medication us cognitive status, "and check list for additional plan. The tool identified its prior to a risk medication, was psychological factor and recently had a safe mobility. In additional tructions and incomplications are reconstructed in the provided in the prov	arge Summary dated 6/21/22, iagnosed with a right hand one fracture related to a fall. Sted orders for R1 to be to her right upper extremity discoupational therapy.  completed 6/21/22, identified icating a high risk for falls. The rpose was "To identify risk for ible causes for actual falls, ance for proper interventions ral factors including history of age, psychological and utomatic high risk" status(s), a conal risk factors and an action ified R1 experienced one or idmission, received one higher is affected by one or more rs, was moderately impaired change in condition affecting dition, the tool identified R1 related to confusion, poor tion, difficulty following continence. The risk factors for and medical remained ction plan was a referral to plan to update the care plan ed.				
	information: -6/26/22: Score of additional identified equipment, dement behavior, impaired tools Action Plan seinterventions.	13.0 (medium fall risk) with risk factors (forgets to use tia, impulsive/risk-taking balance or coordination). The ection was unchecked for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00898	B. WING		08/	01/2022
	PROVIDER OR SUPPLIER  AMARITAN AMBASSA	ADOR 8100 MED	DRESS, CITY, S DICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	difficulties in oriental indicated a referral Action Plan to updatunchecked.  R1's baseline care 6/22/22, identified Fwith impaired though Alzheimer's Disease physical mobility with ambulate or do selfor related to a right has bladder, was diagnouse of antidepressation for falls related to "dincontinence." In action R1's desire to return spouse. The care propose. The care propose. The care propose and what resident as to fall care environmental hazar contribute to falls.  R1's medical recording information:  On 6/22/22, a progrequired frequent satisfies R1 "continually the pafter education on 6/23/22, a progress R1 "continually the first	rs (weight bearing restrictions, ation). The Action Plan to therapy intervention. The ate the care plan remained  plan initiated 6/21/22 through R1 was cognitively impaired the process related to e, demonstrated limited the inability to transfer, for eares without assistance and fracture, was incontinent of osed with COVID-19, required ant medication, and was at risk confusion, history of falls, addition, her care plan identified in to her private condo with her plan listed several interventions and R1 required contact guard eating and fall prevention cate resident about safety to do if a fall occurs, educate auses, and review and modify and that could cause or didentified the following ress note indicated R1 afety checks to prevent falls ransfer[s] without asking for in."  ress note indicated R1 afety checks to prevent falls ransfer[s] without asking for in."				
	An occupational the	erapy (OT) progress note				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00898	B. WING		08/	01/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, STORESS,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	safety awareness a on call light use dur when asked what s use the bathroom FOT note indicated Flocate and use call.  On 6/24/22, a prograble to make need checks due to high diagnosis."  On 6/25/11, a progrataff needs to do from the fall risk r/t (relations Alzheimer's."  A Found on Floor eas:25 a.m. identified front of door" with band tongue with an elbow. R1 stated shooked for someone sent to the hospital the fall, R1 was oriefollowing predisposite to the hospital the fall, R1 was oriefollowing predisposite to the hospital the fall, R1 was oriefollowing predisposite to the hospital the fall, R1 was oriefollowing predisposite to the hospital the fall, R1 was oriefollowing predisposite to the hospital the fall, R1 was oriefollowing predisposite to the hospital the fall, R1 was oriefollowing predisposite to the hospital the fall, R1 was oriefollowing predisposite to the hospital the fall, R1 was oriefollowing predisposite to the hospital the fall was oriefollowed by the fall of the diagnosis, interest and the programment of the fall of the diagnosis, medication and the fall of the f	tified R1 was assessed for nd received extensive training ing the session; however, he should do if she needed to R1 stated, "get up and go." The R1 required "max cues to light this date."  ress note indicated R1 was sknown, but needs frequent fall risk related to Alzheimer's ress note indicated "Nursing equent checks on [R1] due to ated to) confusion from late report, dated 6/26/22, at R1 was found in her room "in blood covering her face, lips, abrasion noted on her left he heard something and thus at to come get her. R1 was for evaluation. At the time of ented only to herself with the ing physiological factors: memory, gait imbalance, and recent illness. The event ince a fall intervention was				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00898	B. WING		08/0	1/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, S ICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	identified R1 was dianxiety, hypertensich dementia and "traut and right foot due to Associated discharg activity level to constright lower extremitione to two pounds extremities, along woccupational therapy occupational therapy occupational therapy occupational therapy occupational therapy occupational therapy of Aphysical therapy of 7/7/22, indicated when R1 self-transferred	arge Summary, dated 6/30/22, iagnosed with COVID-19, on, late onset Alzheimer's matic fractures of both hands of trauma and osteoporosis." ge orders identified R1's sist of non-weight bearing to y and partial weight bearing of for left and right upper with orders for physical and by.  Tess note indicated R1 ity. She required assist of one to be "monitored closely d/t as disoriented to time and cition, required oxygen which emove at times, her right lower leg were ace wrapped, ther call light and was on the	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00898	B. WING		08/0	01/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, S DICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	related to R1's self-On 7/9/22, a progree "noted to self transfi every 2 hours to predict the total through the OT entered on the toilet without movement) special to neither the wheelch bathroom. The noted there on her own." OT updated nursing transfer.  A Found on Floor endicated bathroom floor cover the report indicated the bathroom and stear on her right for R1 was oriented on predisposing physical	ne PT updated nursing staff transfer.  ss note indicated R1 was er in room; safety checks event injury."  te dated 7/14/22, indicated ed R1's room, R1 was noted her CAM (control ankle by boot for protection, and air or walker was in the exincluded, R1 "reports walking There was not evidence the exist staff related to R1's self event report dated 7/22/22, at R1 was found on her ered in blood and fecal matter. If R1 stated she tried to go to lipped. She sustained a skin earm. At the time of the fall, ly to herself with the following blogical factors: confused,	2 830	DEFICIENCY		
	,	and incontinent. In addition, had a CAM boot on her right				
	p.m. indicated R1 we to get out of bed by use her call light to she moved. The pro-	ress note on 7/22/22, at 7:40 as noted by the nurse "trying herself." Staff reminded her to get staff to be with her before ogress note identified R1 she fell at 6:38 p.m.				
	identified R1 was a	a.m. a progress note dmitted to the hospital with hage and r (right) femoral				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00898	B. WING		08/	01/2022
	PROVIDER OR SUPPLIER	ADOR 8100 ME	DDRESS, CITY, S DICINE LAKE PE, MN 55427	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 830	R1's care plan lacks support R1's baseli been assessed/adjuted fall interventions im fall risk after R1's as self-transfer attempt the facility, and after a higher risk for fall. Tool risk factors.  R2's progress notes indicated the resided during the night and to the hospital with A progress note indicated the resided during the night and to the hospital with A progress note indicated the resided during the night and to the hospital with A progress note indicated the resided during the night and to the hospital with assist for toileting. So and required staff a walking and transfer respiratory failure as falls prior to admission least one fall without R2's initial Fall Tool R2 scored 20.0 indications, was maffected and moder affected and modern assist for tool identity; but took two medications, was maffected and modern assist for tool identity.	22/22, prior to her 7/22/22 fall, ed documented evidence to ne fall interventions having usted, or new individualized plemented to decrease R1's ttempted/performed ots, after her initial fall within or she was determined to be at a based on her multiple Fall and Fall Event report ent had fallen on 5/31/22 di was subsequently admitted				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>,</b> , ,	E CONSTRUCTION	COMPLETED	
		00898	B. WING		08/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN AMBASSA	ADOR	ICINE LAKE E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	fatigue, reduced instrumemory. The action therapy. The action remained unchecked R2's subsequent Fatinformation: -5/15/22: Score of 1 additional identified incontinence). Mobil unchecked. The Actiplan was checked.	all Tools identified the following 7.0 (high fall risk) with risk factors (impulsiveness, lity/Transfers status remained tion Plan to update the care				
	plan was checked5/31/22: Score of 17.0 (high fall risk) with additional identified risk factors (impulsive/risk-taking behavior, disorientation, difficulty following instructions, impaired balance and coordination). No other Action Plan interventions were identified6/3/22: Score of 20.0 (high fall risk) with additional identified risk factors (pain, fatigue, change in weight bearing ability, incontinence). The Action Plan intervention was a referral to therapy. The Action Plan to update the care plan remained unchecked.					
	identified R2 experiments related aphasia (difficulty experience) physical mobility an performance related deconditioning, and heart failure where risk care plan identiments weakness, deconditioning (decreased oxygen balance, activity into breath. R2's fall risk	plan initiated 5/13/22, enced communication I to dementia and expressive expressing self), a limitation in d deficits in self-care I to weakness and a diagnosis of congestive she required oxygen. R2's fall fied a fall risk related to tioning, dementia, hypoxia level in tissues), impaired plerance and shortness of a goal was to remain free of the sto remind R2 to use a				

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	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED	
		00898	B. WING		08/0	1/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, S ICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	encourage therapy promotion, and ens footwear during translacked individualize decrease R2's risk risks.  R2's medical record information:  R2's hospital Acute dated 5/4/22, identifying aired cognition with a c	gs up off of the floor, with exercise activity ure she wore appropriate asfers. R2's fall risk care plant difference as fall interventions to of falls based on R2's fall didentified the following  Physical Therapy Evaluation fied R2 demonstrated with short term memory recall s", impaired judgement with wareness, along with astrength and activity uation indicated R2 was at risk and the following interventions: ons, Posey sitter (alarm), system, call light in hand, all a.m. a hospital nursing ated R2 utilized a bed alarm at 2 a.m. a hospital nursing ated [R2] experienced "a near				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00898	B. WING		08/0	1/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, S ICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	fall intervention was R2's fall.  On 5/15/22, at 7:00 lacked evidence a fimmediately after he on 5/15/22, at 10: 2 indicated R2 was obed and the window there for a "long timminutes to one hou was initiated.  On 5/16/22, at 1:49 progress note indicated record in the control of	event report lacked evidence as initiated immediately after  a.m. R2's fall progress note fall intervention was initiated er fall.  20 p.m. a progress note beserved standing between her w. R2 informed staff she stood in e." A safety check every 30 in for prevention of falls/injury  p.m. a Mood/Behavior ated R2 kept trying to stand up she made comments she beathroom. Staff brought R2 to ever, the nurse found R2 in pants by her ankles, crying did not know what to do. The ortable leaving R2 alone in her her out to the dining room. The iffied "All nursing staff was R2] cannot be left alone on the fall risk and is very	2 830			
	indicated the IDT mote identified R2 with impaired cognition awareness and judg her current physical discussed a bedsid R2's dementia seven what a commode with the indicated the identification of the identified R2 with a commode with the identified R2 wi	net and reviewed R2's fall. The vas found on the floor and contributed to poor safety gement with lack of insight into I limitations. The IDT e commode; however, due to erity and inability to recognize vas or its purpose this implemented. IDT's plan was				

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	I OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00898	B. WING		08/0	1/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, S  PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 12	2 830			
	progress notes indicated out of her room every hour for risk of R2's care plan identified risk; her a care plan approach alone on the toilet of staff were to check.  On 5/25/22 a Care identified R2's fall risk discharge; however date for therapy was a plan for her to discare assisted living progress note lacks.	tified on 5/16/22 the ent checks" was initiated due to wever, R2's care plan lacked ch that R2 was not to be left or specific details on how often				
	use her call light or thus staff conducted	ress note indicated R2 did not make her needs known and d frequent safety checks on en numerous times during a high fall risk."				
	1:30 a.m. identified bathroom floor. R2 the bathroom and let to have walked to the R2 displayed a "good head, complained a movement, and her the time of the fall, herself with the following.	vent report dated 5/31/22, at R2 was found lying on the stated she walked back from ost her balance. R2 appeared he bathroom without a device. ose egg" on the side of her of severe left hip pain with r left foot was rotated out. At R2 was oriented only to owing predisposing s: confused and gait				

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AND PLAN OF COF	RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
		00898	B. WING		08/0	1/2022
NAME OF PROVIDE		ADOR 8100 MED	DRESS, CITY, S ICINE LAKE E, MN 5542			
	EACH DEFICIENC	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
imbar fall in fall.  On 5 identification of the control of the con	dervention was  /31/22, at 2:34  /31/22, at 6:56  ated R2 was a  ip fracture, pro- spital shift to sa  /36/1/22, indicates when she e cares versus / for the cares  spital Care Pla as at risk for fa  rentions were de of room, fal entation and rentation and rentation and rentation and rentation shipp  freely assist with w prescribed revention slipp  freely assist with w prescribed respose falling,  spital Discharge fied R2 require hant femur fra  /3/22, a progres status before identified R2 ventation and rentation an	ent report lacked evidence as initiated immediately after her a.m. a progress note at 1:30 a.m.  If a.m. a progress note demitted to the hospital with a eumonia, and low magnesium.  In this summary progress note, ated R2 participated "better" e was instructed it was time if R2 was asked if she	2 830			

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED	
		00898	B. WING		08/0	1/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, S  ICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	"therefore she is free confusion and risk is confirmed R2's wall next to her bed and light before she self reviewed and follow the incident. The profall intervention was fall or with the 6/3/2.  On 6/3/22, a new can and femur fracture assist with mobility, identified a fall risk decision making, whistory of falls, admit therapies, and a Farisk goal was to reminterventions to rempick things up off of with exercise activity wore appropriate for care plan lacked evattempts or any additional concerns." In additional forgetful, restless a attempted to self-trabathroom and as she performed frequent safety.  R2's care plan lacked.	effers to the bathroom, equently checked due to for falls." In addition, the note ker and wheelchair remained she did not activate her call f-toileted. The care plan was wed prior to and during time of rogress note lacked evidence a sinitiated immediately after her 22 fall review.  The plan was initiated for R2. ated R2 experienced a finitiated immediately after her 22 fall review.  The plan was initiated for R2. ated R2 experienced a finite facility for lated to dementia, impaired eakness and deconditioning, finitiated to dementia, impaired eakness and deconditioning, finite facility for lated R2 to use a grabber to fine floor, encourage therapy by promotion, and ensure she follower during transfers. The fidence of R2's self-transfer ditional fall risk interventions.  The ress note indicated R2 to indicated R2 was note indicated R2 was note alled out for help. R2 ansfer when she needed the fire was a high fall risk staff is checks on her to ensure				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00898	B. WING		08/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
COODS		8100 MED	ICINE LAKE	ROAD		
GOOD S	AMARITAN AMBASSA	NEW HOP	E, MN 5542	7		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	discharge plans we	ress note indicated R2's re to discharge on 6/17/22 to acility with hospice (end of life)				
		ress note indicated R2 ssisted living facility.				
	registered nurse (R fell staff were expedinterventions immed followed until the far and either adjusted implemented new of frequent check fall in "purposefully, once walk down the hall door open if we can acknowledged if a flacked a specific tin could check as much indicated R1 experifacility and stated that the foot fracture." So two hour toileting place [R1] knew to check "undocumented und keep our eyes on how y such approach R1's care plan prior confirmed, on 7/22/witnessed R1 attems hift. She explained	on 7/29/22, at 1:56 p.m.  N)-B stated after a resident cted to develop or revise fall diately and these were to be all committee reviewed the fall the intervention(s) or ones. RN-B indicated a ntervention meant every hour, and every time I look in. We try to keep the if they are a fall risk." RN-B requent check intervention he frame for the checks staff ch as they wanted. RN-B enced at least two falls in the ne first one "is what caused he stated R1 was on an every an and "those [staff] that knew on her" and there was an derstanding that we needed to er." She was unable to explain (es) were not initiated into to R1's fall on 7/22/22. She poting self-transfers during her only after R1's 7/22/22, fall plan approach to perform				
	RN-B stated R2 wa staff were "keeping	s on R1 as she was a fall risk. s "a huge fall risk" in which an eye on her." She indicated any other interventions R1				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY. STATE. ZIP CODE  \$100 MEDICINE LAKE ROAD  NEW HOPE, MIN STATE  PROVIDER'S PROVIDER'S PLAN OF CORRECTION  (EACH ISOTROPY OR LISC IDENTIFYING INFORMATION)  2 830 Continued From page 16  utilized to help prevent falls.  During interview on 7/29/22, at 2:25 p.m. nursing assistant (NA)-B stated she referenced the resident's care plan to know resident newsers and sometimes worked with residents she was not initially familiar with. She confirmed she could be scheduled wherever the needs were and sometimes worked with resident who "would just get up and walk" and who presented with "sundowning" symptoms. NA-B explained R1 required a toileting plan and frequent checks however, was unable to remember any additional individualized interventions are more or less." She indicated a resident's care plan to their charting, indicated the time frame for checks. She explained she checked on R1 as frequently as she could while she helped others, and stated the frequency fluctuated based on how busy she was on the unit that shift.  When interviewed on 7/29/22, at 2:41 p.m. NA-A stated she referenced the resident care plans to know resident needs and fall intervention for fall prevention. NA-B stated a frequent checks and fall referenced the time frame for checks. She explained she checked on those residents are plan to know resident needs and fall interventions. NA-A stated she referenced the resident care plans to know resident needs and fall interventions. NA-A explained an intervention of requent checks meant she was to check on that resident every 15 to 30 minutes." She stated R1 was a high fall risk due to past falls and her cognitive status. She was unable to identify specific care planned	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
CACH ID   SUMMARY STATEMENT OF DEFICIENCIES   TAG   SUMMARY STATEMENT OF DEFICIENCIES   TAG			00898	B. WING		08/0	1/2022
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH COMPACTIVE ACTION SHOULD BE (EACH COMPACTION SHOULD SHOULD BE (EACH COMPACTION SHOULD SHOULD BE (EACH COMPACTION SHOU	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG  REGULATORY OR USC IDENTIFYING INFORMATION)  2 830  Continued From page 16  utilized to help prevent falls.  During interview on 7/29/22, at 2:25 p.m. nursing assistant (NA)-B stated she referenced the resident's care plan to know resident needs and fall interventions. NA-B confirmed she could be scheduled wherever the needs were and sometimes worked with residents she was not initially familiar with. She confirmed she could be stated R1 was "kind of hard" to take care of as she was a "demanding" resident who "would just get up and walk" and who presented with "sundowning" symptoms. NA-B explained R1 required a tolleting plan and frequent checks however, was unable to remember any additional individualized interventions for fall prevention. NA-B stated a frequent check fall intervention meant she checked on those residents" usually every hour to make sure they are okay some are every 15 minutes, some are more or less." She indicated a resident's care plan, or their charting, indicated the time frame for checks. She explained she checked on those residents care plan so their charting, indicated the seed on how busy she was on the unit that shift.  When interviewed on 7/29/22, at 2:41 p.m. NA-A stated she referenced the resident care plans to know resident needs and fall interventions for frequent checks meant she was to check on that resident "every 15 to 30 minutes." She stated R1 was a high fall risk due to past falls and her cognitive status. She was unable to identify specific care planned	GOOD S	AMARITAN AMBASSA	ADOR				
utilized to help prevent falls.  During interview on 7/29/22, at 2:25 p.m. nursing assistant (NA)-B stated she referenced the resident's care plan to know resident needs and fall interventions. NA-B confirmed she could be scheduled wherever the needs were and sometimes worked with residents she was not initially familiar with. She confirmed she cid not remember details related to R2 based on length of time since worked with her however, she stated R1 was "kind of hard" to take care of as she was a "demanding" resident who "would just get up and walk" and who presented with "sundowning" symptoms. NA-B explained R1 required a tolleting plan and frequent checks however, was unable to remember any additional individualized interventions for fall prevention. NA-B stated a frequent check fall intervention meant she checked on those residents "usually every hour to make sure they are okay some are every 15 minutes, some are more or less." She indicated a resident's care plan, or their charting, indicated the time frame for checks. She explained she checked on R1 as frequently as she could while she helped others, and stated the frequency fluctuated based on how busy she was on the unit that shift.  When interviewed on 7/29/22, at 2:41 p.m. NA-A stated she referenced the resident care plans to know resident needs and fall interventions. NA-A explained an intervention for frequent checks meant she was to check on that resident "every 15 to 30 minutes." She stated R1 was a high fall risk due to past falls and her cognitive status. She was unable to identify specific care planned	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
interventions for R1; however, she indicated she was instructed by nurses to "keep an eye on [R1] due to her high fall risk" as R1 self-transferred	2 830	During interview on assistant (NA)-B staresident's care plan fall interventions. Nascheduled whereves ometimes worked initially familiar with remember details reof time since worke stated R1 was "kind she was a "demand get up and walk" an "sundowning" symprequired a toileting however, was unabindividualized interv NA-B stated a frequency fluctuated every hour to make are every 15 minuted she indicated a rescharting, indicated the explained she checked explained she checked every hour to make are every 15 minuted she could while she frequency fluctuated on the unit that shift.  When interviewed on the unit that shift. When interviewed an intervention of R1 was instructed by notice that interventions for R1 was instructed by notice that is the context of the c	ent falls.  7/29/22, at 2:25 p.m. nursing ated she referenced the to know resident needs and A-B confirmed she could be the needs were and with residents she was not. She confirmed she did not elated to R2 based on length d with her however, she dof hard" to take care of as ling" resident who "would just and who presented with the stoms. NA-B explained R1 plan and frequent checks le to remember any additional entions for fall prevention. If on those residents "usually sure they are okaysome es, some are more or less." ident's care plan, or their the time frame for checks. She ked on R1 as frequently as a helped others, and stated the dibased on how busy she was a helped other to he helped other to helped other to he helped other to helped o				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			OMPLETED	
		00898	B. WING		08/	01/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, STORESS,	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION CORRECTIVE ACTION CORRECTION	ULD BE	(X5) COMPLETE DATE
2 830	the windownot sure quick." "Each time you have to go whereabouts."  When interviewed partials and second fall. He den staff conducted to a stated during a care talked about her ne indicated R1's biggoremember she was and explained the of from self-transfers on T/2 management. He en her status; however fall caused her current.	ould be taking a nap and then ter she would be standing at ure how she does things so you pass [R1] you have to a do not see her seated in the o in there to see about her out the does not see about her out the facility and an and foot fractures a hip fracture with the facility and ained hand and foot fractures a hip fracture with the facility and ained knowledge of interventions decrease R1's fall risk. He facility and risk. He facility and an action of the facility and ained knowledge of interventions decrease R1's fall risk. He facility and risk issue was she did not not supposed to self-transfer only intervention to stop her was to "strap her to a chair." Insitioned to hospice (end of 18/22, after hip surgery for pain axplained R1's falls did not help risk he did not think the recent ent status.				
	a.m. RN-A stated at "fall huddle" and att intervention as a terminal transfer of the state of th	e up with a "stronger" one.				
	self-transferred whi	ospital." RN-A stated R1 ch was a "frequent behavior ained R1 required "constantly				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00898	B. WING		08/0	1/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN AMBASSA	ADOR	ICINE LAKE E, MN 5542				
(X4) ID PREFIX TAG	/EAGLIBEELQIENGY/AMIGT BE BBEGEBEB BY/ ELLI		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			_D BE	(X5) COMPLETE DATE
2 830	intervention for frequency anyone passed that into the room as the resident doors oper "usually we put a nujust an intervention was "pretty vague." was the main place interventions for residents the facility attempte same units; however they were needed were sidents they were were were to implement they were needed and intervention(s) on the she expected to implement intervention(s) on the she expected all intervention(s) on the she expected all intervention fall risk reduction/prespecially given state were needed and mexpected staff reviets sheets for fall intervention fall risk." She indicated a time frail or two checking on high fall risk." She indicated a time frail plan just indicated for the fall and safety on the fall and safety on frequent checks recollected, on 7/22	and encouraging toileting to RN-A verbalized the uent checks meant every time tresidents room they peeked by attempted to keep those and She followed up with the umber [time frame] on it" as which stated frequent checks RN-A identified the care plan staff went to locate sident care and acknowledged do to schedule staff on the er, staff were scheduled where with the potential to work with unfamiliar with.  In a telephone on 8/1/22, at atted after a fall staff were sent or adjust fall care plan and erventions which assisted with revention to be care planned, and erventions which assisted with revention to be care planned, and group the entions. RN-C identified a antervention meant "every hour them, especially if they are a stated at times the care plan and group them, especially if they are a stated at times the care plan and for the checks or the care requent checks. She stated ons fall around the reason of a fthe resident." She explained that the care and followed up: "RN-C thought she care RN-C t	2 830				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00898		B. WING		08/01/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
		8100 MED	ICINE LAKE	ROAD	
GOOD S	AMARITAN AMBASSA	ADOR NEW HOP	E, MN 5542	7	
(X4) ID PREFIX TAG	(EAGLIBEEIGIENIG) (AUTOF DE DDEGEDED D) (ELLIT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
	therapy aide (PTA)- based on her CAM was so mobile and thought she could of "was doing really we progress with her me bearing restrictions recommendations of lacked recollection interventions despit primary therapists.  When interviewed of manager RN-D state resident fall "some "initiated right away and care planned." were important "so over shift to shift an care." She explaine care planned inform	8/1/22, at 12:30 p.m. physical A stated R1 was a fall risk boot and her cognition: "[R1] with her cognition she just to it." PTA-A explained R1 ell until she fell" and showed nobility despite her weight. PTA-A stated therapy makes for fall risk; however, she of involvement in R1's fall risk to her having been one of R1's end she expected after a sort of intervention" was to be within that [fall] time period Care planned interventions that it [intervention] is carried at it is part of their plan of d if interventions were not nation would not be relayed to staff were overall scheduled	2 830		
	they worked with unstated she was involved which met Monday the interdisciplinary process involved a medical record's sy which tracked facility process was based however, overall after committee reviewed only which encompanies fall note and notifications and in resident's progress the resident fell free	reded and there was a risk afamiliar residents. RN-D alved in the fall committee through Friday and involved team (IDT). The review review of the electronic stem "Risk Management" by events (falls). The review on the fall circumstances; are residents first fall the did the risk management report assed the fall details, the I follow-up, and conducted general did not review the notes section or care plan. If quently the committee gement and the resident's			

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00898	B. WING		08/0	1/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, S ICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	to continue with appreciated the committer risk after a resident and explained she completed upon ad and based on the scareplan was initiate interventions. She scare planned and in the committee had hospital returns to residents fall after a to ensure associate care planned and in the committee had hospital returns to respect to self-transfer dening meant the hall just peeking person is doing In floor or doing all the doing." She denied she expected when checks without a specific enough confirmed R1 and Front specif	tion and the care plan in order broaches or adjust them. She hee re-reviewed falls and fall returned from the hospital expected a Fall Tool to be mission/return and after a fall core and fall history the ed or updated with fall stated a committee review of a hospital return was important and fall risk interventions were applemented. RN-D confirmed not met after R1 and R2's e-evaluate their falls prior to to ensure the care plan				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00898	B. WING		08/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	SAMARITAN AMBASSA	ADOR	ICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 21	2 830			
	resident needs and The goal was to preconfirmed she was and explained the cre-reviewing the fall the hospital to ensurand she expected the documented in the someone is a fall risconversation on how stated a frequent chin when walking by usual checks." The R2 were fall risk resident characteristics.	assisted to decrease fall risk. event falls. The administrator involved in the fall committee committee should be once a resident returned from re appropriate interventions ne re-review to be resident's chart: "if we know sk we really should have a w to prevent a fall" She neck intervention meant "a pop [a resident room]more than administrator stated R1 and sidents.				
During interview on 8/1/22, at 2:19 p.m. the director of nursing (DON) stated she expected after a resident fell that the care plan was reviewed and then adjusted or a new intervention implemented and documented within the care plan. Care planned interventions were important as the care plan directed resident care and safety. She confirmed staff were scheduled where needed and worked with residents they were not familiar with. The DON explained frequent checks meant, "If a resident allows to keep their door open staff just peek in when walking by to make sure they are in a safe spot. If they do not like the door open they try to peekin." Further, she stated, "Staff should be circulating their hall frequently." She explained she preferred timed checks; however, interventions needed to be "realistic" and a resident may not be checked on at designated time frames depending on the needs of the other residents at that time. The DON acknowledged she participated in the fall committee. The committee reviewed falls by viewing the Risk Management event for the fall and ensured all the required components were completed, or followed up on when required. She						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` ′	X3) DATE SURVEY COMPLETED	
		00898	B. WING		08/0	1/2022
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, ST ICINE LAKE I PE, MN 55427	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	adjusted based on interventions were implemented, committed in the details and the care explained with a horassessed for fall risexpected staff to readjustments related risks. She stated Riresidents. The DON the hospital and thuyet met on her 7/22 record lacked documentation on 6/3/22; both R1 (after her returned on 6/3/22; both R1 (after her return on room closer to the remaining a telephone p.m. R2's FM-B state updating him related however, lacked knowever, l	ons were reviewed and the fall information. If not documented as nittee staff interviewed the fall process for additional plan was updated. She spital return the resident was k with a Fall Tool. She view the care plan and make to the residents identified fall 1 and R2 were higher fall risk 1 confirmed R1 remained in the fall committee had not 1/22 fall and confirmed R2's mented evidence the ated her fall risk when she however, she explained for eturn on 6/20/22) and R2 6/3/22) both were moved to a	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		` ′	X3) DATE SURVEY COMPLETED	
		00898	B. WING		08/0	1/2022	
	PROVIDER OR SUPPLIER	ADOR 8100 MED	DRESS, CITY, S DICINE LAKE PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	reviewed/revised 3/began with proactive risk factors and proactions to reduce the identification and printerventions to avoid safety. The packet of care plan was to be cause of the fall was additional falls from an Evaluating Fall Hadmission/Readmist chart directed if a reassessment was 16 fall risk factors and Tool. After, staff we appropriate resident communicate care review the care plan and as needed for eappropriate.  SUGGESTED MET The director of nurse review/revise policies falls, accidents and proper assessment implemented. They policies and proced and monitoring continuity of these auditacility's Quality Assembles.	ource Packet-Rehab/Skilled (30/22, indicated fall reduction ely recognizing potential fall ceeded with communicated he possibility of falls. Early compt communication of oid falls was vital for resident directed that after a fall the checked to determine if the s addressed (to avoid the same cause). In addition, distory at ssion/Duration of Stay flow					

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