P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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 Therefore, the NATCEP prohibition is rescinded.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

*Protecting, Maintaining and Improving the Health of All Minnesotans*

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

*P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s*

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245149 | A. BUILDING ______ B. WING ______ | C 08/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN AMBASSADOR** | **8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On 7/29/22 - 8/1/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be SUBSTANTIATED:<br>H51493527C (MN00085399), with a deficiency cited at F689.<br>H51493648C (MN00083911), with a deficiency cited at F689.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced | F 689 | | 8/22/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/19/2022

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

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| F 689 | Continued From page 1<br>by:<br>Based on interview and document review, the facility failed to comprehensively assess and implement individualized interventions to reduce the risk of falls for 2 of 3 residents (R1, R2) reviewed for accidents. This resulted in actual harm for R1 and R2 who both fell multiple times and obtained fractures which required emergency medical care.<br><br>Findings include:<br><br>A hospital Discharge Summary for R1 dated 6/30/22, identified the resident had sustained fractures of both hands and right foot due to trauma and osteoporosis.<br><br>On 7/23/22, at 5:43 a.m. a progress note identified R1 was admitted to the hospital with "intercranial hemorrhage and r (right) femoral neck fracture" following a fall 7/22/22 at the facility.<br><br>R1's nursing note indicated an admission date of 6/21/22.<br><br>R1's discharge return anticipated Minimum Data Set (MDS) dated 6/26/22, identified R1 required extensive physical assist of one staff for mobility and toileting cares. R1 was free of range of motion limitations in her upper and lower extremities, was occasionally incontinent of bowel and bladder, experienced a fall with injury in the month prior to admission and a fall with major injury since admission, and was diagnosed with a right hand fracture, Alzheimer's Disease, dementia, and COVID-19. Upon hospital return, R1's admission MDS dated 7/6/22, identified R1 was severely cognitively impaired and required | F 689 | R1 and R2 are no longer residents at facility.<br>All current residents were reviewed by Nurse Managers through chart audits for fall risks. Care plans were also reviewed to ensure individualized interventions were current and appropriate for all residents that were found to be at risk for falls. In addition, residents with 2 or more falls since January 2022 have been reviewed by our interdisciplinary team.<br>Comprehensive discussion on fall risks and interventions were completed by the Interdisciplinary team and documented in medical record.<br><br>Licensed Nurses will be educated 8/16/2022 through 8/22/2022 on facility policy and procedures for Fall Management including Falls tool, Comprehensive assessments, implementation of individualized interventions, and care planning. A new process is in place for all new admissions and re-admissions to be audited by the Interdisciplinary team to review fall risk score and ensure comprehensive assessment was completed and individualized interventions were care planned upon admission.<br>.<br>Residents that are at risk for falls will be audited to ensure a comprehensive assessment and individualized care plan is in place for fall prevention measures. Audits will be completed weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the | |

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| F 689 | Continued From page 2 extensive physical assist of two staff for mobility and toileting cares. R1 experienced range of motion limitations to both upper extremities and to one lower extremity, was frequently incontinence of bowel and bladder, and was diagnosed with a right foot fracture and continued discharge return anticipated identified diagnosis.<br><br>R1's hospital Discharge Summary dated 6/21/22, identified R1 was diagnosed with a right hand third metacarpal bone fracture related to a fall. The summary directed orders for R1 to be non-weight bearing to her right upper extremity and for physical and occupational therapy.<br><br>R1's initial Fall Tool completed 6/21/22, identified R1 scored 20.0 indicating a high risk for falls. The tool identified its purpose was "To identify risk for potential falls, possible causes for actual falls, and to provide guidance for proper interventions and reviewed several factors including history of falls, medication usage, psychological and cognitive status, "automatic high risk" status(s), a check list for additional risk factors and an action plan. The tool identified R1 experienced one or more falls prior to admission, received one higher risk medication, was affected by one or more psychological factors, was moderately impaired and recently had a change in condition affecting safe mobility. In addition, the tool identified R1 was at risk for falls related to confusion, poor memory, disorientation, difficulty following instructions and incontinence. The risk factors for mobility/transfers and medical remained unchecked. R1's action plan was a referral to therapy. The action plan to update the care plan remained unchecked.<br><br>R1's subsequent Fall Tools identified the following | F 689 | Nurse Manager. Results of audits will be reviewed by the Director of Nursing for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations. | |

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| F 689 | Continued From page 3 | F 689 | | |

information:
-6/26/22: Score of 13.0 (medium fall risk) with additional identified risk factors (forgets to use equipment, dementia, impulsive/risk-taking behavior, impaired balance or coordination). The tools Action Plan section was unchecked for interventions.
-7/1/22: Score of 20 (high fall risk) with additional identified risk factors (weight bearing restrictions, difficulties in orientation). The Action Plan indicated a referral to therapy intervention. The Action Plan to update the care plan remained unchecked.

R1's baseline care plan initiated 6/21/22 through 6/22/22, identified R1 was cognitively impaired with impaired thought process related to Alzheimer's Disease, demonstrated limited physical mobility with inability to transfer, ambulate or do self-cares without assistance related to a right hand fracture, was incontinent of bladder, was diagnosed with COVID-19, required use of antidepressant medication, and was at risk for falls related to "confusion, history of falls, incontinence." In addition, her care plan identified R1's desire to return to her private condo with her spouse. The care plan listed several interventions for R1 which included R1 required contact guard for mobility and toileting and fall prevention intervention to educate resident about safety reminders and what to do if a fall occurs, educate resident as to fall causes, and review and modify environmental hazards that could cause or contribute to falls.

R1's medical record identified the following information:

On 6/22/22, a progress note indicated R1

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| F 689 | Continued From page 4 | F 689 | | |

required frequent safety checks to prevent falls as R1 "continually transfer[s] without asking for help after education."

On 6/23/22, a progress note indicated"[R1] is able to ambulate but needs reminders to have someone with her to do so ..."

An occupational therapy (OT) progress note dated 6/23/22, identified R1 was assessed for safety awareness and received extensive training on call light use during the session; however, when asked what she should do if she needed to use the bathroom R1 stated, "get up and go." The OT note indicated R1 required "max cues to locate and use call light this date."

On 6/24/22, a progress note indicated R1 was "able to make needs known, but needs frequent checks due to high fall risk related to Alzheimer's diagnosis."

On 6/25/11, a progress note indicated "Nursing staff needs to do frequent checks on [R1] due to high fall risk r/t (related to) confusion from late onset Alzheimer's."

A Found on Floor event report, dated 6/26/22, at 8:25 a.m. identified R1 was found in her room "in front of door" with blood covering her face, lips, and tongue with an abrasion noted on her left elbow. R1 stated she heard something and thus looked for someone to come get her. R1 was sent to the hospital for evaluation. At the time of the fall, R1 was oriented only to herself with the following predisposing physiological factors: confused, impaired memory, gait imbalance, weakness/fainted, and recent illness. The event report lacked evidence a fall intervention was

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| F 689 | Continued From page 5 | F 689 | | |

initiated immediately after R1's fall.

A progress note on 6/27/22, indicated the IDT (interdisciplinary team) met and reviewed R1's fall. The note indicated R1 stated she heard something and looked for someone to get her in which R1 failed to use her call light to ask for assistance. IDT reviewed reason for admission, diagnosis, medication use, age and R1's high risk for falls. IDT's plan was to "re-evaluate patient fall risk status upon return from hospital."

R1's hospital Discharge Summary, dated 6/30/22, identified R1 was diagnosed with COVID-19, anxiety, hypertension, late onset Alzheimer's dementia and "traumatic fractures of both hands and right foot due to trauma and osteoporosis." Associated discharge orders identified R1's activity level to consist of non-weight bearing to right lower extremity and partial weight bearing of one to two pounds for left and right upper extremities, along with orders for physical and occupational therapy.

On 6/30/22, a progress note indicated R1 returned to the facility. She required assist of one staff for transfers, to be "monitored closely d/t (due to) fall risk," was disoriented to time and place, needed direction, required oxygen which she was noted to remove at times, her right arm/hand and right lower leg were ace wrapped, she was oriented to her call light and was on COVID precautions.

On 7/1/22, a progress note indicated R1 changed rooms "d/t safety."

An OT progress note dated 7/1/22, identified per nursing staff, R 1 continued to attempt

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| F 689 | Continued From page 6 self-transfers.<br><br>On 7/4/22, a progress note indicated R1 "was attempting to self transfer" and required a full mechanical lift for all transfers.<br><br>A physical therapy (PT) progress note dated 7/7/22, indicated when the PT entered R1's room, R1 was seated on the toilet. The note indicated R1 self-transferred based on call light not triggered and wheelchair not by bathroom. There was not evidence the PT updated nursing staff related to R1's self-transfer.<br><br>On 7/9/22, a progress note indicated R1 was "noted to self transfer in room; safety checks every 2 hours to prevent injury."<br><br>An OT progress note dated 7/14/22, indicated when the OT entered R1's room, R1 was noted on the toilet without her CAM (control ankle movement) specialty boot for protection, and neither the wheelchair or walker was in the bathroom. The note included, R1 "reports walking there on her own." There was not evidence the OT updated nursing staff related to R1's self transfer.<br><br>A Found on Floor event report dated 7/22/22, at 6:38 p.m. identified R1 was found on her bathroom floor covered in blood and fecal matter. The report indicated R1 stated she tried to go to the bathroom and slipped. She sustained a skin tear on her right forearm. At the time of the fall, R1 was oriented only to herself with the following predisposing physiological factors: confused, impaired memory, gait imbalance, weakness/fainted, and incontinent. In addition, the event noted she had a CAM boot on her right | F 689 | | |

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foot.

A subsequent progress note on 7/22/22, at 7:40 p.m. indicated R1 was noted by the nurse "trying to get out of bed by herself." Staff reminded her to use her call light to get staff to be with her before she moved. The progress note identified R1 failed to remember she fell at 6:38 p.m.

On 7/23/22, at 5:43 a.m. a progress note identified R1 was admitted to the hospital with "intercranial hemorrhage and r (right) femoral neck fracture."

From 6/22/22 to 7/22/22, prior to her 7/22/22 fall, R1's care plan lacked documented evidence to support R1's baseline fall interventions having been assessed/adjusted, or new individualized fall interventions implemented to decrease R1's fall risk after R1's attempted/performed self-transfer attempts, after her initial fall within the facility, and after she was determined to be at a higher risk for falls based on her multiple Fall Tool risk factors.

R2's progress notes and Fall Event report indicated the resident had fallen on 5/31/22 during the night and was subsequently admitted to the hospital with a left hip fracture.

A progress note indicated R2 was admitted to the facility 5/13/22.

R2's admission MDS dated 5/19/22, indicated R2 was severely cognitively impaired. She was able to usually express herself and sometimes understood others. She required limited to extensive assist with her mobility and extensive assist for toileting. She was deemed not steady

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and required staff assist to stabilize her during walking and transfers. Diagnosis included acute respiratory failure and pneumonia. R1 was free of falls prior to admission; however, sustained at least one fall without injury after admission.

R2's initial Fall Tool completed 5/13/22, identified R2 scored 20.0 indicating R2 was at a high risk for falls. The tool identified R2 was free of fall history; but took two or more higher risk medications, was moderately psychologically affected and moderately cognitively impaired. Check marked risk factors identified R2 experienced muscle weakness or strength, fatigue, reduced insight, confusion, and poor memory. The action plan indicated a referral to therapy. The action plan to update the care plan remained unchecked.

R2's subsequent Fall Tools identified the following information:
-5/15/22: Score of 17.0 (high fall risk) with additional identified risk factors (impulsiveness, incontinence). Mobility/Transfers status remained unchecked. The Action Plan to update the care plan was checked.
-5/31/22: 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 identified.
-6/3/22: 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.

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R2's baseline care plan initiated 5/13/22, identified R2 experienced communication impairments related to dementia and expressive aphasia (difficulty expressing self), a limitation in physical mobility and deficits in self-care performance related to weakness and deconditioning, and a diagnosis of congestive heart failure where she required oxygen. R2's fall risk care plan identified a fall risk related to weakness, deconditioning, dementia, hypoxia (decreased oxygen level in tissues), impaired balance, activity intolerance and shortness of breath. R2's fall risk goal was to remain free of falls with interventions to remind R2 to use a grabber to pick things up off of the floor, encourage therapy with exercise activity promotion, and ensure she wore appropriate footwear during transfers. R2's fall risk care plan lacked individualized fall interventions to decrease R2's risk of falls based on R2's fall risks.

R2's medical record identified the following information:

R2's hospital Acute Physical Therapy Evaluation dated 5/4/22, identified R2 demonstrated impaired cognition with short term memory recall "around 20 seconds", impaired judgement with decreased safety awareness, along with decreased balance, strength and activity tolerance. The evaluation indicated R2 was at risk for falls and identified the following interventions: standard interventions, Posey sitter (alarm), seated positioning system, call light in hand, all needs within reach.

On 5/12/22, at 5:05 a.m. a hospital nursing progress note indicated R2 utilized a bed alarm at

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all times for safety.

On 5/12/22, at 10:22 a.m. a hospital nursing progress note indicated [R2] experienced "a near fall, very unsteady on feet ..."

A nursing home Found on Floor event report dated 5/15/22, at 6:26 a.m. identified R2 was found on the floor with her trash can tipped over under her back, her pants and incontinence product were pulled down to her ankle and stool (feces) was found in the trash can. The report indicated at the time of the fall, R2 was oriented only to herself with the following predisposing physiological factors: confused gait imbalance, incontinence. The event report lacked evidence a fall intervention was initiated immediately after R2's fall.

On 5/15/22, at 7:00 a.m. R2's fall progress note lacked evidence a fall intervention was initiated immediately after her fall.

On 5/15/22, at 10: 20 p.m. a progress note indicated R2 was observed standing between her bed and the window. R2 informed staff she stood there for a "long time." A safety check every 30 minutes to one hour for prevention of falls/injury was initiated.

On 5/16/22, at 1:49 p.m. a Mood/Behavior progress note indicated R2 kept trying to stand up during lunch while she made comments she needed to use the bathroom. Staff brought R2 to her bathroom; however, the nurse found R2 standing up with her pants by her ankles, crying and she stated she did not know what to do. The nurse was uncomfortable leaving R2 alone in her room and brought her out to the dining room. The

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progress note identified "All nursing staff was made aware that [R2] cannot be left alone on toilet as she is a high fall risk and is very forgetful."

A progress note on 5/16/22, at 3:54 p.m. indicated the IDT met and reviewed R2's fall. The note identified R2 was found on the floor and impaired cognition contributed to poor safety awareness and judgement with lack of insight into her current physical limitations. The IDT discussed a bedside commode; however, due to R2's dementia severity and inability to recognize what a commode was or its purpose this approach was not implemented. IDT's plan was to perform "frequent checks" on R2.

On 5/16/22, at 8:39 p.m., on 5/18/22, and 5/20/22 progress notes indicated R2 "self-transport[ed] in and out of her room and needs to be monitored every hour for risk of falls."

R2's care plan identified on 5/16/22 the intervention "frequent checks" was initiated due to her high fall risk; however, R2's care plan lacked a care plan approach that R2 was not to be left alone on the toilet or specific details on how often staff were to check on R2.

On 5/25/22 a Care Conference progress note identified R2's fall risk was a barrier to her discharge; however, R2's anticipated transition date for therapy was documented as 5/31/22 with a plan for her to discharge back to her memory care assisted living facility on 6/1/22. The progress note lacked additional fall risk information or intervention discussion related to fall risk.

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On 5/29/22, a progress note indicated R2 did not use her call light or make her needs known and thus staff conducted frequent safety checks on R2 as "she has fallen numerous times during current stay and is a high fall risk."

A Found on Floor event report dated 5/31/22, at 1:30 a.m. identified R2 was found lying on the bathroom floor. R2 stated she walked back from the bathroom and lost her balance. R2 appeared to have walked to the bathroom without a device. R2 displayed a "goose egg" on the side of her head, complained of severe left hip pain with movement, and her left foot was rotated out. At the time of the fall, R2 was oriented only to herself with the following predisposing physiological factors: confused and gait imbalance. The event report lacked evidence a fall intervention was initiated immediately after her fall.

On 5/31/22, at 2:34 a.m. a progress note identified R2's fall at 1:30 a.m.

On 5/31/22, at 6:56 a.m. a progress note indicated R2 was admitted to the hospital with a left hip fracture, pneumonia, and low magnesium.

A hospital shift to shift summary progress note, dated 6/1/22, indicated R2 participated "better" with cares when she was instructed it was time for the cares versus if R2 was asked if she was ready for the cares.

A hospital Care Plan note dated 6/2/22, identified R2 was at risk for falls in which the following interventions were in place: fall risk light on outside of room, fall risk sticker on door, fall prevention reminders to R2, frequent

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re-orientation and repetitive reminders to ask for assistance, high risk armband on, hi-lo bed, keep assistive device close at all times, bed alarm on, fall prevention slippers, stay within arm's reach and offer/assist with toileting every two hours, review prescribed medications that could predispose falling, and physical therapy.

A hospital Discharge Summary, dated 6/3/22, identified R2 required surgery for a left inter trenchant femur fracture

On 6/3/22, a progress note indicated a review of R2's status before and after her 5/31/22 fall. The note identified R2 was cognitively impaired secondary to dementia with a SLUMS (cognitive test) of 5/30, she was incontinent of bladder, call light use was inconsistent, she displayed a pattern of self-transfers to the bathroom, "therefore she is frequently checked due to confusion and risk for falls." In addition, the note confirmed R2's walker and wheelchair remained next to her bed and she did not activate her call light before she self-toileted. The care plan was reviewed and followed prior to and during time of the incident. The progress note lacked evidence a fall intervention was initiated immediately after her fall or with the 6/3/22 fall review.

On 6/3/22, a new care plan was initiated for R2. The care plan indicated R2 experienced a self-care performance deficit related to recent fall and femur fracture with interventions R2 required assist with mobility. R2's fall risk care plan identified a fall risk related to dementia, impaired decision making, weakness and deconditioning, history of falls, admission to the facility for therapies, and a Falls Tool score of 20. R2's fall risk goal was to remain free of falls with

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| F 689 | Continued From page 14<br>interventions to remind R2 to use a grabber to pick things up off of the floor, encourage therapy with exercise activity promotion, and ensure she wore appropriate footwear during transfers. The care plan lacked evidence of R2's self-transfer attempts or any additional fall risk interventions.<br><br>On 6/10/22, a progress note indicated R2 required daily monitoring due to " ...safety concerns." In addition, the note indicated R2 was forgetful, restless and called out for help. R2 attempted to self-transfer when she needed the bathroom and as she was a high fall risk staff performed frequent checks on her to ensure safety.<br><br>R2's care plan lacked evidence of her self-transfer attempts or any additional fall risk interventions.<br><br>On 6/16/22, a progress note indicated R2's discharge plans were to discharge on 6/17/22 to her assisted living facility with hospice (end of life) services.<br><br>On 6/17/22, a progress note indicated R2 discharged to her assisted living facility.<br><br>When interviewed on 7/29/22, at 1:56 p.m. registered nurse (RN)-B stated after a resident fell staff were expected to develop or revise fall interventions immediately and these were to be followed until the fall committee reviewed the fall and either adjusted the intervention(s) or implemented new ones. RN-B indicated a frequent check fall intervention meant "purposefully, once every hour, and every time I walk down the hall I look in. We try to keep the door open if we can if they are a fall risk." RN-B | F 689 | | |

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acknowledged if a frequent check intervention lacked a specific time frame for the checks staff could check as much as they wanted. RN-B indicated R1 experienced at least two falls in the facility and stated the first one "is what caused the foot fracture." She stated R1 was on an every two hour toileting plan and "those [staff] that knew [R1] knew to check on her" and there was an "undocumented understanding that we needed to keep our eyes on her." She was unable to explain why such approach(es) were not initiated into R1's care plan prior to R1's fall on 7/22/22. She confirmed, on 7/22/22 before R1's fall, she witnessed R1 attempting self-transfers during her shift. She explained only after R1's 7/22/22, fall she initiated a care plan approach to perform hourly safety checks on R1 as she was a fall risk. RN-B stated R2 was "a huge fall risk" in which staff were "keeping an eye on her." She indicated she was unsure of any other interventions R1 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 did 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 toileting plan and frequent checks however, was unable to remember any additional individualized interventions for fall prevention. NA-B stated a frequent check fall intervention

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| F 689 | Continued From page 16<br>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.<br><br>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 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 "every day:" "[R1] could be taking a nap and then 10 to 15 minutes later she would be standing at the window ...not sure how she does things so quick." "Each time you pass [R1] you have to peek on her ...if you do not see her seated in the chair you have to go in there to see about her whereabouts."<br><br>When interviewed per telephone on 7/29/22, at 3:45 p.m. R1's family member (FM-A) stated he was aware of R1's two falls in the facility and verbalized she sustained hand and foot fractures with the first fall and a hip fracture with the second fall. He denied knowledge of interventions staff conducted to decrease R1's fall risk. He stated during a care conference staff "mainly talked about her needing memory care." He indicated R1's biggest issue was she did not | F 689 | | |

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remember she was not supposed to self-transfer and explained the only intervention to stop her from self-transfers was to "strap her to a chair." FM-A stated R1 transitioned to hospice (end of life) services on 7/28/22, after hip surgery for pain management. He explained R1's falls did not help her status; however, he did not think the recent fall caused her current status.

During a telephone interview on 8/1/22, at 11:36 a.m. RN-A stated after each fall staff performed a "fall huddle" and attempted to come up with a fall intervention as a team which they care planned. This intervention would then be reviewed by the fall committee who either adjusted the intervention or came up with a "stronger" one. RN-A stated she failed to remember if interventions were initiated after R1 fell on 7/22/22 however, commented the "priority was getting her to the hospital." RN-A stated R1 self-transferred which was a "frequent behavior for her." RN-A explained R1 required "constantly peeking in on her and encouraging toileting to help prevent falls." RN-A verbalized the intervention for frequent checks meant every time anyone passed that residents room they peeked into the room as they attempted to keep those resident doors open. She followed up with "usually we put a number [time frame] on it" as just an intervention which stated frequent checks was "pretty vague." RN-A identified the care plan was the main place staff went to locate interventions for resident care and acknowledged the facility attempted to schedule staff on the same units; however, staff were scheduled where they were needed with the potential to work with residents they were unfamiliar with.

When interviewed via telephone on 8/1/22, at

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| F 689 | Continued From page 18<br>11:57 a.m. RN-C stated after a fall staff were expected to implement or adjust fall care plan intervention(s) on the shift the fall occurred and she expected all interventions which assisted with fall risk reduction/prevention to be care planned, especially given staff were scheduled where they were needed and may not know the resident. She expected staff reviewed the care plan and group sheets for fall interventions. RN-C identified a frequent check fall intervention meant "every hour or two checking on them, especially if they are a high fall risk." She stated at times the care plan indicated a time frame for the checks or the care plan just indicated frequent checks. She stated "basically interventions fall around the reason of the fall and safety of the resident." She explained R1 "tend[ed] to self-transfer" and followed up: "She has a history of falls, that is why we had her on frequent checks." RN-C thought she recollected, on 7/22/22 after R1's fall, she updated R1's care plan to toilet her right after supper to decrease falls.<br><br>During interview on 8/1/22, at 12:30 p.m. physical therapy aide (PTA)-A stated R1 was a fall risk based on her CAM boot and her cognition: "[R1] was so mobile and with her cognition she just thought she could do it." PTA-A explained R1 "was doing really well until she fell" and showed progress with her mobility despite her weight bearing restrictions. PTA-A stated therapy makes recommendations for fall risk; however, she lacked recollection of involvement in R1's fall risk interventions despite her having been one of R1's primary therapists.<br><br>When interviewed on 8/1/22, at 12:57 p.m. care manager RN-D stated she expected after a resident fall "some sort of intervention" was to be | F 689 | | |

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| GOOD SAMARITAN AMBASSADOR | 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427 |

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| F 689 | Continued From page 19 "initiated right away within that [fall] time period and care planned." Care planned interventions were important "so that it [intervention] is carried over shift to shift and it is part of their plan of care." She explained if interventions were not care planned information would not be relayed to staff and confirmed staff were overall scheduled where they were needed and there was a risk they worked with unfamiliar residents. RN-D stated she was involved in the fall committee which met Monday through Friday and involved the interdisciplinary team (IDT). The review process involved a review of the electronic medical record's system "Risk Management" which tracked facility events (falls). The review process was based on the fall circumstances; however, overall after a residents first fall the committee reviewed the risk management report only which encompassed the fall details, the nurses fall note and follow-up, and conducted notifications and in general did not review the resident's progress notes section or care plan. If the resident fell frequently the committee reviewed risk management and the resident's progress notes section and the care plan in order to continue with approaches or adjust them. She denied the committee re-reviewed falls and fall risk after a resident returned from the hospital and explained she expected a Fall Tool to be completed upon admission/return and after a fall and based on the score and fall history the careplan was initiated or updated with fall interventions. She stated a committee review of a residents fall after a hospital return was important to ensure associated fall risk interventions were care planned and implemented. RN-D confirmed the committee had not met after R1 and R2's hospital returns to re-evaluate their falls prior to hospitalization and to ensure the care plan | F 689 | | |

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| F 689 | Continued From page 20<br>encompassed individualized fall risk interventions. She stated a frequent check fall intervention meant "when [staff] are walking down the hall just peeking in the room to see what the person is doing ...making sure they are not on the floor or doing all those things they should not be doing." She denied she educated staff on what she expected when a care plan indicated frequent checks without a specific time frame despite her comment that a frequent check intervention was not specific enough to ensure safety. RN-D confirmed R1 and R2 were at risk for falls based on their Fall Tool scores and both were observed to self-transfer during their stay(s). She stated R1's and R2's care plans lacked individualized fall interventions to decrease their fall risk based on their risk factors and observed self-transferring behavior.<br><br>When interviewed on 8/1/22, at 1:54 p.m. the administrator stated she expected staff to follow their fall policy and expected a fall intervention to be put into place immediately after a fall which was documented/reflected in the care plan. This action helped with staff communication of resident needs and assisted to decrease fall risk. The goal was to prevent falls. The administrator confirmed she was involved in the fall committee and explained the committee should be re-reviewing the fall once a resident returned from the hospital to ensure appropriate interventions and she expected the re-review to be documented in the resident's chart: "if we know someone is a fall risk we really should have a conversation on how to prevent a fall ..." She stated a frequent check intervention meant "a pop in when walking by [a resident room] ...more than usual checks." The administrator stated R1 and R2 were fall risk residents. | F 689 | | |

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| F 689 | Continued From page 21 | F 689 | | |

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 explained interventions were reviewed and adjusted based on the fall information. If interventions were not documented as implemented, committee staff interviewed the staff involved in the fall process for additional details and the care plan was updated. She explained with a hospital return the resident was assessed for fall risk with a Fall Tool. She expected staff to review the care plan and make adjustments related to the residents identified fall risks. She stated R1 and R2 were higher fall risk residents. The DON confirmed R1 remained in the hospital and thus the fall committee had not

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| F 689 | Continued From page 22<br>yet met on her 7/22/22 fall and confirmed R2's record lacked documented evidence the committee re-evaluated her fall risk when she returned on 6/3/22; however, she explained for both R1 (after her return on 6/20/22) and R2 (after her return on 6/3/22) both were moved to a room closer to the nurse's station.<br><br>During a telephone interview on 8/1/22, at 3:57 p.m. R2's FM-B stated he remembered staff updating him related to R2's fall on 5/31/22 however, lacked knowledge R2 had fallen earlier in her stay. In addition, he stated he didn't remember being involved in discussions related to fall interventions. He stated he witnessed staff reminding R2 she needed to push her call light button if she needed something: "I knew there was no way in hell she was going to remember that." FM-B also said R2 was considerably more confused due to her hospital stay and different surroundings. FM-B stated R2 passed away on 6/23/22 after her discharge from the nursing home to the assisted living. FM-B stated, "After the broken hip she had what the doctor called failing to thrive. She was not eating. She kind of gave up."<br><br>A facility Falls Resource Packet-Rehab/Skilled reviewed/revised 3/30/22, indicated fall reduction began with proactively recognizing potential fall risk factors and proceeded with communicated actions to reduce the possibility of falls. Early identification and prompt communication of interventions to avoid falls was vital for resident safety. The packet directed that after a fall the care plan was to be checked to determine if the cause of the fall was addressed (to avoid additional falls from the same cause). In addition, an Evaluating Fall History at | F 689 | | |

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| F 689 | Continued From page 23<br>Admission/Readmission/Duration of Stay flow chart directed if a resident's Falls Took assessment was 16 or more staff were to identify fall risk factors and intervention plan in the Falls Tool. After, staff were to choose the most appropriate resident specific interventions, communicate care plan to staff and to then review the care plan approaches at least quarterly and as needed for effectiveness and modify as appropriate. | F 689 | | |

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 00898 | A. BUILDING: ______ B. WING ______ | 08/01/2022 |

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| 2 000 | Initial Comments | 2 000 | | |

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 7/29/22 - 8/1/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure.

The following complainst were found to be

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| 2 000 | Continued From page 1<br><br>SUBSTANTIATED: H51493527C (MN00085399) and H51493648C (MN00083911) a licensing order was cited at 4658.0520 Subdivision 1.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to comprehensively assess and implement individualized interventions to reduce the risk of falls for 2 of 3 residents (R1, R2) reviewed for accidents. This resulted in actual | 2 830 | R1 and R2 are no longer residents at facility.<br>All current residents were reviewed by Nurse Managers through chart audits for fall risks. Care plans were also reviewed | 8/22/22 |

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| 2 830 | Continued From page 2<br>harm for R1 and R2 who both fell multiple times and obtained fractures which required emergency medical care.<br><br>Findings include:<br><br>A hospital Discharge Summary for R1 dated 6/30/22, identified the resident had sustained fractures of both hands and right foot due to trauma and osteoporosis.<br><br>On 7/23/22, at 5:43 a.m. a progress note identified R1 was admitted to the hospital with "intercranial hemorrhage and r (right) femoral neck fracture" following a fall 7/22/22 at the facility.<br><br>R1's nursing note indicated an admission date of 6/21/22.<br><br>R1's discharge return anticipated Minimum Data Set (MDS) dated 6/26/22, identified R1 required extensive physical assist of one staff for mobility and toileting cares. R1 was free of range of motion limitations in her upper and lower extremities, was occasionally incontinent of bowel and bladder, experienced a fall with injury in the month prior to admission and a fall with major injury since admission, and was diagnosed with a right hand fracture, Alzheimer's Disease, dementia, and COVID-19. Upon hospital return, R1's admission MDS dated 7/6/22, identified R1 was severely cognitively impaired and required extensive physical assist of two staff for mobility and toileting cares. R1 experienced range of motion limitations to both upper extremities and to one lower extremity, was frequently incontinence of bowel and bladder, and was diagnosed with a right foot fracture and continued discharge return anticipated identified diagnosis. | 2 830 | to ensure individualized interventions were current and appropriate for all residents that were found to be at risk for falls. In addition, residents with 2 or more falls since January 2022 have been reviewed by our interdisciplinary team. Comprehensive discussion on fall risks and interventions were completed by the Interdisciplinary team and documented in medical record.<br><br>Licensed Nurses will be educated 8/16/2022 through 8/22/2022 on facility policy and procedures for Fall Management including Falls tool, Comprehensive assessments, implementation of individualized interventions, and care planning. A new process is in place for all new admissions and re-admissions to be audited by the Interdisciplinary team to review fall risk score and ensure comprehensive assessment was completed and individualized interventions were care planned upon admission.<br>.<br>Residents that are at risk for falls will be audited to ensure a comprehensive assessment and individualized care plan is in place for fall prevention measures. Audits will be completed weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed by the Director of Nursing for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations. | |

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| 2 830 | Continued From page 3 | 2 830 | | |

R1's hospital Discharge Summary dated 6/21/22, identified R1 was diagnosed with a right hand third metacarpal bone fracture related to a fall. The summary directed orders for R1 to be non-weight bearing to her right upper extremity and for physical and occupational therapy.

R1's initial Fall Tool completed 6/21/22, identified R1 scored 20.0 indicating a high risk for falls. The tool identified its purpose was "To identify risk for potential falls, possible causes for actual falls, and to provide guidance for proper interventions and reviewed several factors including history of falls, medication usage, psychological and cognitive status, "automatic high risk" status(s), a check list for additional risk factors and an action plan. The tool identified R1 experienced one or more falls prior to admission, received one higher risk medication, was affected by one or more psychological factors, was moderately impaired and recently had a change in condition affecting safe mobility. In addition, the tool identified R1 was at risk for falls related to confusion, poor memory, disorientation, difficulty following instructions and incontinence. The risk factors for mobility/transfers and medical remained unchecked. R1's action plan was a referral to therapy. The action plan to update the care plan remained unchecked.

R1's subsequent Fall Tools identified the following information:
-6/26/22: Score of 13.0 (medium fall risk) with additional identified risk factors (forgets to use equipment, dementia, impulsive/risk-taking behavior, impaired balance or coordination). The tools Action Plan section was unchecked for interventions.
-7/1/22: Score of 20 (high fall risk) with additional

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| 2 830 | Continued From page 4 | 2 830 | | |

identified risk factors (weight bearing restrictions, difficulties in orientation). The Action Plan indicated a referral to therapy intervention. The Action Plan to update the care plan remained unchecked.

R1's baseline care plan initiated 6/21/22 through 6/22/22, identified R1 was cognitively impaired with impaired thought process related to Alzheimer's Disease, demonstrated limited physical mobility with inability to transfer, ambulate or do self-cares without assistance related to a right hand fracture, was incontinent of bladder, was diagnosed with COVID-19, required use of antidepressant medication, and was at risk for falls related to "confusion, history of falls, incontinence." In addition, her care plan identified R1's desire to return to her private condo with her spouse. The care plan listed several interventions for R1 which included R1 required contact guard for mobility and toileting and fall prevention intervention to educate resident about safety reminders and what to do if a fall occurs, educate resident as to fall causes, and review and modify environmental hazards that could cause or contribute to falls.

R1's medical record identified the following information:

On 6/22/22, a progress note indicated R1 required frequent safety checks to prevent falls as R1 "continually transfer[s] without asking for help after education."

On 6/23/22, a progress note indicated"[R1] is able to ambulate but needs reminders to have someone with her to do so ..."

An occupational therapy (OT) progress note

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dated 6/23/22, identified R1 was assessed for safety awareness and received extensive training on call light use during the session; however, when asked what she should do if she needed to use the bathroom R1 stated, "get up and go." The OT note indicated R1 required "max cues to locate and use call light this date."

On 6/24/22, a progress note indicated R1 was "able to make needs known, but needs frequent checks due to high fall risk related to Alzheimer's diagnosis."

On 6/25/11, a progress note indicated "Nursing staff needs to do frequent checks on [R1] due to high fall risk r/t (related to) confusion from late onset Alzheimer's."

A Found on Floor event report, dated 6/26/22, at 8:25 a.m. identified R1 was found in her room "in front of door" with blood covering her face, lips, and tongue with an abrasion noted on her left elbow. R1 stated she heard something and thus looked for someone to come get her. R1 was sent to the hospital for evaluation. At the time of the fall, R1 was oriented only to herself with the following predisposing physiological factors: confused, impaired memory, gait imbalance, weakness/fainted, and recent illness. The event report lacked evidence a fall intervention was initiated immediately after R1's fall.

A progress note on 6/27/22, indicated the IDT (interdisciplinary team) met and reviewed R1's fall. The note indicated R1 stated she heard something and looked for someone to get her in which R1 failed to use her call light to ask for assistance. IDT reviewed reason for admission, diagnosis, medication use, age and R1's high risk for falls. IDT's plan was to "re-evaluate patient fall

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| 2 830 | Continued From page 6<br>risk status upon return from hospital."<br><br>R1's hospital Discharge Summary, dated 6/30/22, identified R1 was diagnosed with COVID-19, anxiety, hypertension, late onset Alzheimer's dementia and "traumatic fractures of both hands and right foot due to trauma and osteoporosis." Associated discharge orders identified R1's activity level to consist of non-weight bearing to right lower extremity and partial weight bearing of one to two pounds for left and right upper extremities, along with orders for physical and occupational therapy.<br><br>On 6/30/22, a progress note indicated R1 returned to the facility. She required assist of one staff for transfers, to be "monitored closely d/t (due to) fall risk," was disoriented to time and place, needed direction, required oxygen which she was noted to remove at times, her right arm/hand and right lower leg were ace wrapped, she was oriented to her call light and was on COVID precautions.<br><br>On 7/1/22, a progress note indicated R1 changed rooms "d/t safety."<br><br>An OT progress note dated 7/1/22, identified per nursing staff, R 1 continued to attempt self-transfers.<br><br>On 7/4/22, a progress note indicated R1 "was attempting to self transfer" and required a full mechanical lift for all transfers.<br><br>A physical therapy (PT) progress note dated 7/7/22, indicated when the PT entered R1's room, R1 was seated on the toilet. The note indicated R1 self-transferred based on call light not triggered and wheelchair not by bathroom. There | 2 830 | | |

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was not evidence the PT updated nursing staff related to R1's self-transfer.

On 7/9/22, a progress note indicated R1 was "noted to self transfer in room; safety checks every 2 hours to prevent injury."

An OT progress note dated 7/14/22, indicated when the OT entered R1's room, R1 was noted on the toilet without her CAM (control ankle movement) specialty boot for protection, and neither the wheelchair or walker was in the bathroom. The note included, R1 "reports walking there on her own." There was not evidence the OT updated nursing staff related to R1's self transfer.

A Found on Floor event report dated 7/22/22, at 6:38 p.m. identified R1 was found on her bathroom floor covered in blood and fecal matter. The report indicated R1 stated she tried to go to the bathroom and slipped. She sustained a skin tear on her right forearm. At the time of the fall, R1 was oriented only to herself with the following predisposing physiological factors: confused, impaired memory, gait imbalance, weakness/fainted, and incontinent. In addition, the event noted she had a CAM boot on her right foot.

A subsequent progress note on 7/22/22, at 7:40 p.m. indicated R1 was noted by the nurse "trying to get out of bed by herself." Staff reminded her to use her call light to get staff to be with her before she moved. The progress note identified R1 failed to remember she fell at 6:38 p.m.

On 7/23/22, at 5:43 a.m. a progress note identified R1 was admitted to the hospital with "intercranial hemorrhage and r (right) femoral

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neck fracture."

From 6/22/22 to 7/22/22, prior to her 7/22/22 fall, R1's care plan lacked documented evidence to support R1's baseline fall interventions having been assessed/adjusted, or new individualized fall interventions implemented to decrease R1's fall risk after R1's attempted/performed self-transfer attempts, after her initial fall within the facility, and after she was determined to be at a higher risk for falls based on her multiple Fall Tool risk factors.

R2's progress notes and Fall Event report indicated the resident had fallen on 5/31/22 during the night and was subsequently admitted to the hospital with a left hip fracture.

A progress note indicated R2 was admitted to the facility 5/13/22.

R2's admission MDS dated 5/19/22, indicated R2 was severely cognitively impaired. She was able to usually express herself and sometimes understood others. She required limited to extensive assist with her mobility and extensive assist for toileting. She was deemed not steady and required staff assist to stabilize her during walking and transfers. Diagnosis included acute respiratory failure and pneumonia. R1 was free of falls prior to admission; however, sustained at least one fall without injury after admission.

R2's initial Fall Tool completed 5/13/22, identified R2 scored 20.0 indicating R2 was at a high risk for falls. The tool identified R2 was free of fall history; but took two or more higher risk medications, was moderately psychologically affected and moderately cognitively impaired. Check marked risk factors identified R2

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| 2 830 | Continued From page 9<br>experienced muscle weakness or strength, fatigue, reduced insight, confusion, and poor memory. The action plan indicated a referral to therapy. The action plan to update the care plan remained unchecked.<br><br>R2's subsequent Fall Tools identified the following information:<br>-5/15/22: Score of 17.0 (high fall risk) with additional identified risk factors (impulsiveness, incontinence). Mobility/Transfers status remained unchecked. The Action Plan to update the care plan was checked.<br>-5/31/22: 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 identified.<br>-6/3/22: 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.<br><br>R2's baseline care plan initiated 5/13/22, identified R2 experienced communication impairments related to dementia and expressive aphasia (difficulty expressing self), a limitation in physical mobility and deficits in self-care performance related to weakness and deconditioning, and a diagnosis of congestive heart failure where she required oxygen. R2's fall risk care plan identified a fall risk related to weakness, deconditioning, dementia, hypoxia (decreased oxygen level in tissues), impaired balance, activity intolerance and shortness of breath. R2's fall risk goal was to remain free of falls with interventions to remind R2 to use a | 2 830 | | |

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grabber to pick things up off of the floor, encourage therapy with exercise activity promotion, and ensure she wore appropriate footwear during transfers. R2's fall risk care plan lacked individualized fall interventions to decrease R2's risk of falls based on R2's fall risks.

R2's medical record identified the following information:

R2's hospital Acute Physical Therapy Evaluation dated 5/4/22, identified R2 demonstrated impaired cognition with short term memory recall "around 20 seconds", impaired judgement with decreased safety awareness, along with decreased balance, strength and activity tolerance. The evaluation indicated R2 was at risk for falls and identified the following interventions: standard interventions, Posey sitter (alarm), seated positioning system, call light in hand, all needs within reach.

On 5/12/22, at 5:05 a.m. a hospital nursing progress note indicated R2 utilized a bed alarm at all times for safety.

On 5/12/22, at 10:22 a.m. a hospital nursing progress note indicated [R2] experienced "a near fall, very unsteady on feet ..."

A nursing home Found on Floor event report dated 5/15/22, at 6:26 a.m. identified R2 was found on the floor with her trash can tipped over under her back, her pants and incontinence product were pulled down to her ankle and stool (feces) was found in the trash can. The report indicated at the time of the fall, R2 was oriented only to herself with the following predisposing physiological factors: confused gait imbalance,

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incontinence. The event report lacked evidence a fall intervention was initiated immediately after R2's fall.

On 5/15/22, at 7:00 a.m. R2's fall progress note lacked evidence a fall intervention was initiated immediately after her fall.

On 5/15/22, at 10: 20 p.m. a progress note indicated R2 was observed standing between her bed and the window. R2 informed staff she stood there for a "long time." A safety check every 30 minutes to one hour for prevention of falls/injury was initiated.

On 5/16/22, at 1:49 p.m. a Mood/Behavior progress note indicated R2 kept trying to stand up during lunch while she made comments she needed to use the bathroom. Staff brought R2 to her bathroom; however, the nurse found R2 standing up with her pants by her ankles, crying and she stated she did not know what to do. The nurse was uncomfortable leaving R2 alone in her room and brought her out to the dining room. The progress note identified "All nursing staff was made aware that [R2] cannot be left alone on toilet as she is a high fall risk and is very forgetful."

A progress note on 5/16/22, at 3:54 p.m. indicated the IDT met and reviewed R2's fall. The note identified R2 was found on the floor and impaired cognition contributed to poor safety awareness and judgement with lack of insight into her current physical limitations. The IDT discussed a bedside commode; however, due to R2's dementia severity and inability to recognize what a commode was or its purpose this approach was not implemented. IDT's plan was to perform "frequent checks" on R2.

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| 2 830 | Continued From page 12<br><br>On 5/16/22, at 8:39 p.m., on 5/18/22, and 5/20/22 progress notes indicated R2 "self-transport[ed] in and out of her room and needs to be monitored every hour for risk of falls."<br><br>R2's care plan identified on 5/16/22 the intervention "frequent checks" was initiated due to her high fall risk; however, R2's care plan lacked a care plan approach that R2 was not to be left alone on the toilet or specific details on how often staff were to check on R2.<br><br>On 5/25/22 a Care Conference progress note identified R2's fall risk was a barrier to her discharge; however, R2's anticipated transition date for therapy was documented as 5/31/22 with a plan for her to discharge back to her memory care assisted living facility on 6/1/22. The progress note lacked additional fall risk information or intervention discussion related to fall risk.<br><br>On 5/29/22, a progress note indicated R2 did not use her call light or make her needs known and thus staff conducted frequent safety checks on R2 as "she has fallen numerous times during current stay and is a high fall risk."<br><br>A Found on Floor event report dated 5/31/22, at 1:30 a.m. identified R2 was found lying on the bathroom floor. R2 stated she walked back from the bathroom and lost her balance. R2 appeared to have walked to the bathroom without a device. R2 displayed a "goose egg" on the side of her head, complained of severe left hip pain with movement, and her left foot was rotated out. At the time of the fall, R2 was oriented only to herself with the following predisposing physiological factors: confused and gait | 2 830 | | |

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imbalance. The event report lacked evidence a fall intervention was initiated immediately after her fall.

On 5/31/22, at 2:34 a.m. a progress note identified R2's fall at 1:30 a.m.

On 5/31/22, at 6:56 a.m. a progress note indicated R2 was admitted to the hospital with a left hip fracture, pneumonia, and low magnesium.

A hospital shift to shift summary progress note, dated 6/1/22, indicated R2 participated "better" with cares when she was instructed it was time for the cares versus if R2 was asked if she was ready for the cares.

A hospital Care Plan note dated 6/2/22, identified R2 was at risk for falls in which the following interventions were in place: fall risk light on outside of room, fall risk sticker on door, fall prevention reminders to R2, frequent re-orientation and repetitive reminders to ask for assistance, high risk armband on, hi-lo bed, keep assistive device close at all times, bed alarm on, fall prevention slippers, stay within arm's reach and offer/assist with toileting every two hours, review prescribed medications that could predispose falling, and physical therapy.

A hospital Discharge Summary, dated 6/3/22, identified R2 required surgery for a left inter trenchant femur fracture

On 6/3/22, a progress note indicated a review of R2's status before and after her 5/31/22 fall. The note identified R2 was cognitively impaired secondary to dementia with a SLUMS (cognitive test) of 5/30, she was incontinent of bladder, call light use was inconsistent, she displayed a

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pattern of self-transfers to the bathroom, "therefore she is frequently checked due to confusion and risk for falls." In addition, the note confirmed R2's walker and wheelchair remained next to her bed and she did not activate her call light before she self-toileted. The care plan was reviewed and followed prior to and during time of the incident. The progress note lacked evidence a fall intervention was initiated immediately after her fall or with the 6/3/22 fall review.

On 6/3/22, a new care plan was initiated for R2. The care plan indicated R2 experienced a self-care performance deficit related to recent fall and femur fracture with interventions R2 required assist with mobility. R2's fall risk care plan identified a fall risk related to dementia, impaired decision making, weakness and deconditioning, history of falls, admission to the facility for therapies, and a Falls Tool score of 20. R2's fall risk goal was to remain free of falls with interventions to remind R2 to use a grabber to pick things up off of the floor, encourage therapy with exercise activity promotion, and ensure she wore appropriate footwear during transfers. The care plan lacked evidence of R2's self-transfer attempts or any additional fall risk interventions.

On 6/10/22, a progress note indicated R2 required daily monitoring due to " ...safety concerns." In addition, the note indicated R2 was forgetful, restless and called out for help. R2 attempted to self-transfer when she needed the bathroom and as she was a high fall risk staff performed frequent checks on her to ensure safety.

R2's care plan lacked evidence of her self-transfer attempts or any additional fall risk interventions.

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On 6/16/22, a progress note indicated R2's discharge plans were to discharge on 6/17/22 to her assisted living facility with hospice (end of life) services.

On 6/17/22, a progress note indicated R2 discharged to her assisted living facility.

When interviewed on 7/29/22, at 1:56 p.m. registered nurse (RN)-B stated after a resident fell staff were expected to develop or revise fall interventions immediately and these were to be followed until the fall committee reviewed the fall and either adjusted the intervention(s) or implemented new ones. RN-B indicated a frequent check fall intervention meant "purposefully, once every hour, and every time I walk down the hall I look in. We try to keep the door open if we can if they are a fall risk." RN-B acknowledged if a frequent check intervention lacked a specific time frame for the checks staff could check as much as they wanted. RN-B indicated R1 experienced at least two falls in the facility and stated the first one "is what caused the foot fracture." She stated R1 was on an every two hour toileting plan and "those [staff] that knew [R1] knew to check on her" and there was an "undocumented understanding that we needed to keep our eyes on her." She was unable to explain why such approach(es) were not initiated into R1's care plan prior to R1's fall on 7/22/22. She confirmed, on 7/22/22 before R1's fall, she witnessed R1 attempting self-transfers during her shift. She explained only after R1's 7/22/22, fall she initiated a care plan approach to perform hourly safety checks on R1 as she was a fall risk. RN-B stated R2 was "a huge fall risk" in which staff were "keeping an eye on her." She indicated she was unsure of any other interventions R1

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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 did 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 toileting 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 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

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"every day:" "[R1] could be taking a nap and then 10 to 15 minutes later she would be standing at the window ...not sure how she does things so quick." "Each time you pass [R1] you have to peek on her ...if you do not see her seated in the chair you have to go in there to see about her whereabouts."

When interviewed per telephone on 7/29/22, at 3:45 p.m. R1's family member (FM-A) stated he was aware of R1's two falls in the facility and verbalized she sustained hand and foot fractures with the first fall and a hip fracture with the second fall. He denied knowledge of interventions staff conducted to decrease R1's fall risk. He stated during a care conference staff "mainly talked about her needing memory care." He indicated R1's biggest issue was she did not remember she was not supposed to self-transfer and explained the only intervention to stop her from self-transfers was to "strap her to a chair." FM-A stated R1 transitioned to hospice (end of life) services on 7/28/22, after hip surgery for pain management. He explained R1's falls did not help her status; however, he did not think the recent fall caused her current status.

During a telephone interview on 8/1/22, at 11:36 a.m. RN-A stated after each fall staff performed a "fall huddle" and attempted to come up with a fall intervention as a team which they care planned. This intervention would then be reviewed by the fall committee who either adjusted the intervention or came up with a "stronger" one. RN-A stated she failed to remember if interventions were initiated after R1 fell on 7/22/22 however, commented the "priority was getting her to the hospital." RN-A stated R1 self-transferred which was a "frequent behavior for her." RN-A explained R1 required "constantly

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| 2 830 | Continued From page 18<br>peeking in on her and encouraging toileting to help prevent falls." RN-A verbalized the intervention for frequent checks meant every time anyone passed that residents room they peeked into the room as they attempted to keep those resident doors open. She followed up with "usually we put a number [time frame] on it" as just an intervention which stated frequent checks was "pretty vague." RN-A identified the care plan was the main place staff went to locate interventions for resident care and acknowledged the facility attempted to schedule staff on the same units; however, staff were scheduled where they were needed with the potential to work with residents they were unfamiliar with.<br><br>When interviewed via telephone on 8/1/22, at 11:57 a.m. RN-C stated after a fall staff were expected to implement or adjust fall care plan intervention(s) on the shift the fall occurred and she expected all interventions which assisted with fall risk reduction/prevention to be care planned, especially given staff were scheduled where they were needed and may not know the resident. She expected staff reviewed the care plan and group sheets for fall interventions. RN-C identified a frequent check fall intervention meant "every hour or two checking on them, especially if they are a high fall risk." She stated at times the care plan indicated a time frame for the checks or the care plan just indicated frequent checks. She stated "basically interventions fall around the reason of the fall and safety of the resident." She explained R1 "tend[ed] to self-transfer" and followed up: "She has a history of falls, that is why we had her on frequent checks." RN-C thought she recollected, on 7/22/22 after R1's fall, she updated R1's care plan to toilet her right after supper to decrease falls. | 2 830 | | |

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| 2 830 | Continued From page 19<br><br>During interview on 8/1/22, at 12:30 p.m. physical therapy aide (PTA)-A stated R1 was a fall risk based on her CAM boot and her cognition: "[R1] was so mobile and with her cognition she just thought she could do it." PTA-A explained R1 "was doing really well until she fell" and showed progress with her mobility despite her weight bearing restrictions. PTA-A stated therapy makes recommendations for fall risk; however, she lacked recollection of involvement in R1's fall risk interventions despite her having been one of R1's primary therapists.<br><br>When interviewed on 8/1/22, at 12:57 p.m. care manager RN-D stated she expected after a resident fall "some sort of intervention" was to be "initiated right away within that [fall] time period and care planned." Care planned interventions were important "so that it [intervention] is carried over shift to shift and it is part of their plan of care." She explained if interventions were not care planned information would not be relayed to staff and confirmed staff were overall scheduled where they were needed and there was a risk they worked with unfamiliar residents. RN-D stated she was involved in the fall committee which met Monday through Friday and involved the interdisciplinary team (IDT). The review process involved a review of the electronic medical record's system "Risk Management" which tracked facility events (falls). The review process was based on the fall circumstances; however, overall after a residents first fall the committee reviewed the risk management report only which encompassed the fall details, the nurses fall note and follow-up, and conducted notifications and in general did not review the resident's progress notes section or care plan. If the resident fell frequently the committee reviewed risk management and the resident's | 2 830 | | |

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| 2 830 | Continued From page 20<br>progress notes section and the care plan in order to continue with approaches or adjust them. She denied the committee re-reviewed falls and fall risk after a resident returned from the hospital and explained she expected a Fall Tool to be completed upon admission/return and after a fall and based on the score and fall history the careplan was initiated or updated with fall interventions. She stated a committee review of a residents fall after a hospital return was important to ensure associated fall risk interventions were care planned and implemented. RN-D confirmed the committee had not met after R1 and R2's hospital returns to re-evaluate their falls prior to hospitalization and to ensure the care plan encompassed individualized fall risk interventions. She stated a frequent check fall intervention meant "when [staff] are walking down the hall just peeking in the room to see what the person is doing ...making sure they are not on the floor or doing all those things they should not be doing." She denied she educated staff on what she expected when a care plan indicated frequent checks without a specific time frame despite her comment that a frequent check intervention was not specific enough to ensure safety. RN-D confirmed R1 and R2 were at risk for falls based on their Fall Tool scores and both were observed to self-transfer during their stay(s). She stated R1's and R2's care plans lacked individualized fall interventions to decrease their fall risk based on their risk factors and observed self-transferring behavior.<br><br>When interviewed on 8/1/22, at 1:54 p.m. the administrator stated she expected staff to follow their fall policy and expected a fall intervention to be put into place immediately after a fall which was documented/reflected in the care plan. This action helped with staff communication of | 2 830 | | |

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| 2 830 | Continued From page 21<br>resident needs and assisted to decrease fall risk. The goal was to prevent falls. The administrator confirmed she was involved in the fall committee and explained the committee should be re-reviewing the fall once a resident returned from the hospital to ensure appropriate interventions and she expected the re-review to be documented in the resident's chart: "if we know someone is a fall risk we really should have a conversation on how to prevent a fall ..." She stated a frequent check intervention meant "a pop in when walking by [a resident room] ...more than usual checks." The administrator stated R1 and R2 were fall risk residents.<br><br>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 | 2 830 | | |

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| 2 830 | Continued From page 22<br>explained interventions were reviewed and adjusted based on the fall information. If interventions were not documented as implemented, committee staff interviewed the staff involved in the fall process for additional details and the care plan was updated. She explained with a hospital return the resident was assessed for fall risk with a Fall Tool. She expected staff to review the care plan and make adjustments related to the residents identified fall risks. She stated R1 and R2 were higher fall risk residents. The DON confirmed R1 remained in the hospital and thus the fall committee had not yet met on her 7/22/22 fall and confirmed R2's record lacked documented evidence the committee re-evaluated her fall risk when she returned on 6/3/22; however, she explained for both R1 (after her return on 6/20/22) and R2 (after her return on 6/3/22) both were moved to a room closer to the nurse's station.<br><br>During a telephone interview on 8/1/22, at 3:57 p.m. R2's FM-B stated he remembered staff updating him related to R2's fall on 5/31/22 however, lacked knowledge R2 had fallen earlier in her stay. In addition, he stated he didn't remember being involved in discussions related to fall interventions. He stated he witnessed staff reminding R2 she needed to push her call light button if she needed something: "I knew there was no way in hell she was going to remember that." FM-B also said R2 was considerably more confused due to her hospital stay and different surroundings. FM-B stated R2 passed away on 6/23/22 after her discharge from the nursing home to the assisted living. FM-B stated, "After the broken hip she had what the doctor called failing to thrive. She was not eating. She kind of gave up." | 2 830 | | |

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A facility Falls Resource Packet-Rehab/Skilled reviewed/revised 3/30/22, indicated fall reduction began with proactively recognizing potential fall risk factors and proceeded with communicated actions to reduce the possibility of falls. Early identification and prompt communication of interventions to avoid falls was vital for resident safety. The packet directed that after a fall the care plan was to be checked to determine if the cause of the fall was addressed (to avoid additional falls from the same cause). In addition, an Evaluating Fall History at Admission/Readmission/Duration of Stay flow chart directed if a resident's Falls Took assessment was 16 or more staff were to identify fall risk factors and intervention plan in the Falls Tool. After, staff were to choose the most appropriate resident specific interventions, communicate care plan to staff and to then review the care plan approaches at least quarterly and as needed for effectiveness and modify as appropriate.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.